How Do Art Therapists Interact with People and their Artworks in a Mentalization-Based Art Therapy Group?

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Abstract

Art therapy research studies neglect the description of practice. A literature review revealed that art therapists narrowly rely on self-reported case studies to build theory, but that approach tends to result in a description of the therapist's intention rather than the actions they undertook. Comparable forms of psychological therapy have constructed descriptions of practice from observational research but this method has been relatively underused by art therapists.

The present study used observation to build a description of practice of how art therapists interacted with service users and their artworks in a mentalization-based art therapy group for people diagnosed with borderline personality disorder. Three fifteen minute video edited sequences of *in vivo* art therapy sessions were viewed by focus groups who described what they observed. Because the study assumed a social constructionist epistemology, focus groups were chosen to represent a range of service users, psychological therapists, art therapists and the treating art therapists' perspectives. A modified grounded theory approach was used to analyse transcripts from those focus groups which resulted in two core conceptual categories. The first proposed that when art therapists demonstrated their engaged attention, it supported a more reliable therapeutic interaction. The second, conversely, proposed that when the art therapists gave the appearance of passivity, it exacerbated dismissive interactions between group members and with artworks. This added new theoretical concepts to art therapy group literature. However, that theory was not tested in the present study.

Keywords: art therapy; borderline personality disorder; observational research; grounded theory.

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Glossary of Abbreviations

A&TA: Attachment and the arts, annual multi-disciplinary

AIR: Audio-image recording, a digital recording format using artwork and dialogue

ATPRN: Art Therapy Practice Research Network,

BAAT: British Association of Art Therapists

BAAT-PDSIG: British Association of Art Therapists personality disorder special interest group

BPD: Borderline personality disorder

BPDSI: Borderline Personality Disorder Severity Index

BSI: Brief Symptom Inventory

CORE-OM: Clinical outcome and routine evaluation outcome evaluation tool

DSM: Diagnostic and Statistical Manual

DTS: Distress Tolerance Scale

EBCD: Experience based co-design, an approach developed by the Kings Fund to involve both service users and providers in developing NHS procedures.

ICD: International Classification of Mental and Behavioural Disorders

MATISSE: Multi-centre study of art therapy in schizophrenia

MBT: Mentalization based therapy

Mini-PAS-ADD: Assessment schedule for detection of mental health problems in adults with developmental disabilities

NICE: National Institute for Clinical Excellence

NIMHE: National Institute for Mental Health England

OXT: Oxytocin, a neuro-peptide thought to be highly implicated in attachment

RCT: Randomised control trial

RF: Reflective functioning, a heuristic measure of mentalization

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Introduction

As a practitioner working with people diagnosed with borderline personality disorder, I have often found myself wondering how I could practice art therapy every week yet struggle to find words to describe that practice. In a later part of my career I undertook metalization-based therapy training and I found its language had an essential fit with the feel of and actions in the practice. Because it was predominantly a verbal model, mentalization-based therapy still left a gap about how to interact with service users and their art. That three way area of interaction between art therapist, service user and artwork has long been termed the triangular relationship in art therapy literature. However, whilst the term provided a name for a feature of art therapy, it offered little to describe what an art therapist actually *does* in the triangular relationship.

I argue it is important to have descriptions of art therapy practice because lack of clarity of terms poses significant threats to the validity of any research undertaken in the field. Moreover, people diagnosed with borderline personality disorder come to art therapy seeking help for profound mental distress. It is of ethical importance that they are informed as fully as possible about the help they are going to be offered.

The present study aimed to produce a grounded theory description of the art therapist's action within the triangular relationship. The study used a literature review to reveal that most art therapy theory had relied on therapist-reported case studies. The research that followed this literature review used four focus groups to describe video edited sequences of *in vivo* art therapy for people with borderline personality disorder. A grounded theory method was used to develop a set of propositions about how art therapists interacted with service users and their artworks based on the observations of the focus groups. The thesis is structured to reflect these stages of the research process.

The first chapter describes the epistemology which was social constructionism. I placed this chapter first because the epistemology of the researcher foreshadows all decisions made in a study. Social constructionism demands a high degree of reflexivity about context, the use of terminology and a critical stance towards claims made about the scope of knowledge. These considerations therefore shaped the approach taken to the literature review, main study and conclusion.

Chapters two to four form a literature review. The literature review was undertaken to ascertain the current state of, and gaps in, relevant knowledge as preparation for the main study. The relevance of literature to be searched was determined by the research question, which was: How do art therapists interact with service users and their visual artworks (the triangular relationship) during the discussion section of mentalization-based art therapy groups aimed at treating people with personality disorder? This question identified the need to review literature in following subject areas, as related to art therapy:

1. Definition of practice
2. Triangular relationship
3. Group work
4. Mentalization
5. Borderline personality disorder.

The contents page outlines how these subject areas were cross-referenced in the literature review.

Chapters five to eight introduce how the main study was constructed. Because the literature review revealed that many of the procedures needed to observe art therapy group-work were untried, a feasibility study needed to be undertaken prior to the main study. The feasibility study is described in chapter five and its results formed the basis of the methodology for the main study. Chapter six describes the procedures used in the main

study and details how the epistemology related to grounded theory method of analysis. Chapter seven presents the findings and includes the grounded theory construction processes, tables of codes and an integrative diagram with description of the grounded theory as a set of propositions. Chapter eight concludes with a statement of the thesis and its relationship to existing theory. This chapter ends the thesis with a discussion of the implications for practice, research and my epistemology.

Chapter One: Epistemology

The present study assumed a social constructionist epistemology. This is a complex paradigm to describe because it has been applied widely, developed numerous strands of enquiry and in so doing developed controversies. For this reason, I have chosen to clarify its basic tenets by tracing the historical development of the concept. Given the present study took place in the UK National Health Service (NHS), I pay particular attention to its contribution to the field of evidence based medicine. Following this, I outline the critical debates within social constructionism, with particular emphasis ontology as this has been a highly disputed discourse.

Social constructionism offers a critique of the positivistic notion that claiming to uncover truth is politically neutral and aims to illuminate the often hidden social processes involved in the science. Research is assumed to always be an intentional act in the service of those who undertake it. For this reason I include a section about my personal relationship to this epistemology, detailing my investments, biases and beliefs. I describe how I personally became sensitised to the issues involved, how that shaped my view on art, art therapy and research. I pay particular attention to the two main subject areas I chose to focus on in the present study, namely mentalization-based therapy (MBT) and observational methodology. I conclude the chapter by defining my intention in using specific terminology. The terms service user and borderline personality disorder have historically been used in many different ways, often contentiously and therefore their specific purpose and meaning in the present study requires clarification.

Development of Social Constructionism

The development of what is currently termed social constructionism cannot be traced to a single origin, but instead brings together a number of philosophical and cultural movements. Mir & Watson, (2000) suggest the earliest proponent of the principle of

knowledge as perception, rather than facsimile of reality, was Socrates but it was in the nineteenth century that this notion was substantially expanded upon. The work of Karl Marx (1844) on false consciousness was interested in how both employees and employers conformed to their allotted roles in society. Even when these roles were oppressive, Marx observed that they were adhered to as if they were a given reality beyond question. For Marx, the focus on the links between the individual and the capitalist system around them was the only way to understand how thought could become so alienated from the thinker. In doing so he offered a model where an individual's assumptions and perceptions, although subjectively experienced as personal, could be seen to be internalised representations from the cultural context they inhabited. Durkhiem's (1897) use of sociological methods to explore the phenomena of suicide offered a similar challenge to the presumption that such events were determined by biological or moral mechanisms located in the individual. At the same time the arts and philosophy developed a postmodern discourse which challenged prevailing assumptions that that art and culture were driven by some underlying moral principle towards improvement. The particular term postmodernism has been traced to the 1870s disputes that impressionism, as a modernist movement, was progressive and that any further approaches to painting must therefore necessarily justify its contribution to that same progression (Hassans, 1987). Postmodernism was later widened to critiques of wider culture and religion by Thomson (1914). Similar discourses then followed in a form of critical theory that challenged positivism in the sciences. Positivism assumed that universal laws could be deduced by verifiable logical and mathematical approaches. Mead (1934) criticised the scope of such claims, particularly in respect to equating the removal of personal bias with revealing objective truth, which he termed naive realism. Instead he proposed a model where validity in scientific knowledge could be increased through reflective and self-critical

means. This form of hermeneutics became concerned with knowledge gained through the interpretation of text, meaning the symbolic expressions of human beings, such as writing or art, which could be read for their intention (Haberman, 1967). The moral purpose for science in this paradigm was not the unearthing of objective truth, but to: "Liberate human beings from the circumstances that enslave them." (Horkenheimer, 1967). The 1960s saw an increase in the development of approaches which would now be described as social constructionist, and they did so as an explicit critique of positivism.

Berger and Luckman's (1966) seminal critique of the social construction of reality originated from the work of the Chicago school of sociology after Mead. They proposed a model of symbolic interactionalism to understand how socially constructed views of truth, be that science or societal norms, became shared versions of reality. They proposed that solutions to specific problems in everyday life became progressively habitualised through repetition as an efficiency for those who employed them. As these habits were repeated they were then externalised into anonnymised institutional symbolic forms. Primary amongst those institutionalised forms were reciprocal roles and rhetorical language use. These forms were then reified and presented as truth to new generations. By reciprocating, the roles and language were internalised and taken as reality itself by new generations. In this respect, symbolic interactional shares some principles with Marx's notion of false consciousness, though Berger and Luckman were more concerned with the social process of reality construction and less concerned with the corollary notion that a *true* consciousness might exist. Berger and Luckman posited that those who did not reciprocate with the roles offered to them would require marginalisation because their refusal destabilised the basic social process of institutionalisation.

In describing reality construction as a social purpose, symbolic interactionalism explicitly linked positivist scientific with the politics of power. Becker's (1963)

sociological examination of the process of scientific research suggested the scientists' claims could be considered a kind of “social entrepreneurism” by self-defined elites. Star (2007) noted that even though the scientific process is part of the relational world, “... scientists are normatively discouraged to write directly about this invisible part and are untrained in its analysis.” (p. 75). The insistence on avoiding the term “I” and use of the third person in many scientific styles was cited as a rhetorical device to obscure bias and imply objectivity. Foucault (1976) further examined how knowledge claims as discourses created rigid social positions for individuals. He also suggested this power was most successful when it hid its own mechanisms. He pursued the notion of research as the archaeology of knowledge, where knowledge claims could be deconstructed through analysis of the discourses used and the social positioning they imposed on the persons involved. Foucault had a profound impact on the way those diagnosed with a mental illness were positioned in society. Brown (1995) summarised the social construction of mental illness as: "Diagnosis locates the parameters of normal and abnormal and demarcates the professional and institutional boundaries of the social system" (p. 43). Because the present study occurred within the public mental health system I wish now to specifically focus on the social constructionist contribution to theory in that field.

Social constructionism and the evidence based medicine paradigm. In The UK the National Institute for Clinical Excellence (NICE) is the body which offers guidance as to the most reliable evidence for treatment in the NHS. It uses a process where it summarises what it defines as the evidence base and issues guidance for clinicians and commissioners of services. It adheres to the principle of evidence based medicine in that it claims to be a scientific means of targeting effective treatment to illnesses and of utilising finite financial resources for the best health outcomes (Hicks, 1998). Evidence based medicine draws heavily on epidemiology, which is the branch of medicine which deals

with the incidence, distribution, and possible control of diseases including other factors relating to health. In psychiatry many decisions are based around a process where epidemiological information has been operationalised into a diagnostic manual. The long development of the US diagnostic and statistical manual (DSM) has been extensively critiqued by social constructionists and so offers an insight into the assumptions and biases involved in evidence based medicine.

The DSM has drawn extensively on information about populations to substantiate its objectivity claims. Over time this has resulted in an exponential growth of diagnostic categories of mental illness. For example, the 1840 US Census Bureau had only one classification of mental illness: idiocy. In 1844 the American Psychiatric Association was formed in and its first statistical manual in 1918 used US Census Bureau information as evidence to substantiate categories of individuals who should be compulsorily detained in mental institutions. From this first manual the number of diagnoses increased with each DSM issued as follows: DSM-II (163); DSM-III (224) and DSM-IV (374). Positivist proponents of the DSM argued the increase in diagnostic categories demonstrated improved knowledge about mental illnesses (Perez-Alverez & Garcia-Montez, 2007). Social constructionists examined the social and contextual factors involved in this growth. Frances (2013) argued that the growth in mental health diagnosis more closely correlated with the development of psychiatric medications than advances in the understanding of mental health conditions. The so called "epidemic of depression" was a case in point (Mirowsky & Ross, 1999). The DSM-III listed depression as a minor diagnosis. DSM-IV classified it as a major mental disease, which resulted in more people receiving the diagnosis just as more antidepressants had come onto the market. Luhrmann (2000) examined the process of psychiatric diagnosis and similarly observed a common "teleological adjustment" (p. 9) where for example, psychiatrists listened to people

diagnosed as bi-polar and where their symptoms did not respond to the lithium offered to treat it, the diagnosis was routinely changed to schizophrenia.

Mirowski & Ross (1999) characterised the American Psychiatric Association as a battleground between medical doctors and psychoanalysts for which profession would become the warranting voice for mental health treatment in the US. The justification put forward by the medical professionals in DSM for the increase in the disease model was not the effect of medications, but the notion of determining physiological factors, particularly genetic inheritance. However, because there were limited tests for that inheritance at that point, this argument presumed psychiatrists could intuit the biochemical abnormality they claim existed through their process of diagnosis (Brown 1995). The construction process of the DSM involved similar irrationalities. The final content of each DSM was validated by a process of consensus amongst the committee. As the chief DSM negotiator for this process, Robert Spitzer (1985) observed these debates were often factionalised and "differences could not be resolved by appeal to objective data" (p. 532). The increase in psychiatric diagnoses in DSM represented the ultimate victory of the medical profession over the psychoanalytic in the association.

In compiling evidence for evidence based medicine in the UK, NICE views the randomised control trial (RCT) as the "gold standard" of clinical research into effective treatment of illnesses. It is argued that RCTs have a high clarity of factors focused on and bias control, which NICE equates with objectivity. However: "It is virtually impossible to decide which factors are important and consequently matching them becomes a subjective decision on the part of the experimenter" (Hicks, 1998, p. 26). Very often it is the social world which is relegated to epiphenomena to the mental health condition being studied in the RCT (Brown 1995). A study by Marx (1988) found a RCT achieved its results only by using a language for statements about bias and confounding which were evaluable only by

reference to its own terms: "a self-authenticating criterion" masquerading as an objective truth. This subjective process of choice has been routinely obscured in the RCT literature. Grimes & Schultz (1996) found 81 percent of RCTs published no methodology at all. Lau (1998) found that where methodology was published, differences in procedures and biases made many RCT fundamentally incompatible with each other and so undermined the meta-analysis claimed to increase the objectivity of RCTs evidence for NICE. It also has been argued the consideration of the social world as a variable in RCTs has disadvantaged their employment in researching non-medical mental health practices such as social psychiatry (Haigh, 2003) or psychotherapy (Mullen & Streiner, 2004; Strauss & McAllister, 2000).

Studies within the social constructionist paradigm indicate that positivist assumptions that the social world as epiphenomena can be mutually reinforced through diagnostic practice based on the manuals which made that proposition. Terkelsen (2009) observed that psychiatrists routinely ignored the content of patient experiences and limited themselves to only checking the frequency of symptoms in relation to the medication they prescribed. It was observed that after several experiences of this approach, service users began to reciprocate by bringing only those symptoms to the consultation that conformed to the psychiatrist's question. Mirowsky and Ross (1999) bluntly criticised the process: "Diagnosis is a two part process of gathering information then ignoring it" (p. 19).

Pragmatic interests of claims makers. Social constructionists have offered a valuable critique of research as a neutral act of uncovering truth by reframing science as a process of developing products for the pragmatic needs of the communities that use them (Berkwits, 1998). With respect to mental illness, the interests of claim makers can be detected from the earliest point. In 1844 the confederate congressman John Calhoun used census information to claim freed slaves suffered more mental illness than those

incarcerated (Connor-Greene, 2006) Similarly the southern state physician Samuel Cartwright (1851) claimed expert medical observation and the invocation of obscure Latinised terminology had allowed him to identify disease entities which drove the impulse of slaves to flee their masters ("Drapetomanid") and a malaise that overcame slaves who had been permitted too much freedom ("Dysaethesia Aethiopica"). This had lasting consequences. Schnifkes, Freese and Powell (2000) found the US black community retained more negative views towards genetic and medical descriptions of mental illness because it obscured issues of inequality in social conditions. Social constructionism has also revealed the powerful commercial interests involved taking that approach. For example, medications for children with supposed conduct disorders such as Attention Deficit Disorder, a highly contested diagnosis, represent a £3 billion dollar pharmaceutical worldwide market (Lloyd, Stead, Cohen, 2008). Social constructionist criticisms have had some effect in this regard as the DSM-V agreed to reduce the threshold of compilers fee from drug companies down to $10,000.00 per year.

Social constructionism critiques have encouraged important questions to be asked about the scientific process: “The theoretical position held by researchers not only guides but determines what gets constructed as a research problems and what constitutes observations and evidence” (Boyd, 1991, p. 90). This is highly pertinent to the construction of mental illness. For example, Repper and Perkins (2007) observed that the mental health service user’s voice had long been neglected in policy and research in the UK because it was assumed they lacked insight and therefore had nothing valid to contribute. Most long term studies did not use outcomes valued by mental health service users (McLeod, 2001; Gibbard & Hanley, 2008; Hunter et al., 2004; Simpson et al., 2003). There has been a dearth of research into the subjective experience of psychological therapy independent of therapist or researcher measures and constructs (Bedi Davis &

Williams, 2005; Elliot & James, 1989). The Consumer Research Advisory Group Conference specifically looked into mental health service user priorities for research. They found many service users saw professional research as biased and driven by career advancement, power and control (Rose et al., 2006). Service users found such research inaccessible and failed to see the link to practical improvements in services. Service users typically prioritised differently from professional research, emphasising non-medical aspects of mental health such as social context, self-help and recovery (Palmer et al., 2009; Rose et al., 2006). These discourses have shaped very little of the publically funded mental health landscape in the UK.

Discussion of evidence based medicine paradigm. Should NICE maintain its positivist assumption of equating elimination of social factors with objectivity, arguably, it must always see RCTs as the stronger evidence. The preference for RCTs could be said to build in a bias for medical research over social research. This has profound implications for who has the warranting voice in shaping mental services. In suggesting this I would not wish to imply that psychological RCTs have not been valued by therapists beyond the considerations of commissioning. Lillenfeld (2007) suggested RCTs were essential in guiding therapists by identifying harmful psychological therapies for post-traumatic stress disorder, for example. Neither would I wish to suggest that medical approaches have made no positive contribution to mental health. Instead, I perceive the greater problem in the evidenced based medicine paradigm is epistemological: "If we only ask medical questions we only get medical answers" (Lloyd, Stead, Cohen, 2008, p. 138).

The contribution of the positivistic approach to evidence based medicine in mental health cannot claim great success. A large scale study by Warner (1985) found people diagnosed with schizophrenia recovered less in developed countries than in countries which did not have advanced medical health facilities. Despite this, positivist evidence

based medicine still dominates the UK public health systems. How this "reality" of mental illness continues to grow as a construct in western culture has been studied through symbolic interactionalism terms (Perez-Alverez & Garcia-Montez, 2007). First there is a deficit translation of life's ordinary problems which are identified in the mental illness discourse. Cultural dissemination makes mental disorders common everyday concepts and in this way cultural construction teaches everybody to be ill. The accompanying vocabulary expansion makes the medicalisation and psychologicalisation of everyday life seem real. Similarly, ethnographic studies also suggest that mental illness diagnosis often had a self-fulfilling prophesy effect on the people who received them. A study identified a process of rejection was mutually enacted between professionals and patients whereby patients expected rejection, undertook the very defensive strategies that then confirmed the diagnosis which then led to rejection by professionals (Aviram, Brodsky & Stanley 2006; Link, Cullen, Struening, Shrouf & Donrenwend 1998; Swann and Ussher, 1995).

Many of the pioneering social constructionist research studies above were concerned with types of discourse analysis which offered a valuable balance to the positivist claims made in the name of "objective reality." Social constructionist critiques can claim a pragmatic validity by pointing to the achievement of societal change in the post war period. Goffman’s (1961, 1963) work on mental health asylums and stigma for example did much to highlight how the use of power in the name of medical science was used to label unwanted behaviours and attitudes as “mental illness” with profound consequences for civil liberties. In the UK this type of critique contributed greatly to the closure of the asylums (Community Care Act, 1990). More latterly it has led to the addition of recovery practices alongside the traditional medical approaches (Palmer et al., 2009). That said, social constructionism has been subject to intense criticism and it is to this that I now wish to give attention.

Critical debates in social constructionism. Critics of social constructionism argue that by positioning itself as a corrective for positivism, it becomes a dependant epistemology incapable of developing its own theory (Burr, 2003). This poses particular difficulties for psychology. For example, by claiming "there is nothing outside of the text" (Derrida, 1976, p. 158), some have suggested the individual is merely cast as passive product of narrative, resulting what Craibe (1984) called the "death of the subject." Willig (2001) was similarly critical of the lack of concern in social constructionism for personal subjectivity, self awareness and individual history. Parker (1999) cautioned that constructionist theory too often saw agency and subjectivity as problematically originating from, or residing in, the individual and so dismissed them. Therefore, whilst social constructionism might show the iatrogenic harm that systems do by labeling the individual, it has offered less to alleviate the suffering of individuals who come to those systems seeking help (Georgia, 2013). These criticisms of the social constructionist paradigm have been described as problematic for research which aims to guide mental health practice for individuals. Burr (2003) suggested that merely theorising how people are negotiators of positions says nothing about how those processes are supposed to operate. She questioned how social constructionism might explain the individual's emotional investment in discourse positions particularly when positions do not work in their favour.

Other critics have referred to a problematic anti-realist position within social constructionist research. Collier (1998) suggested the social construction epistemology had inherent limits which if extended too far resulted in a dogma of social relativism. In this respect the epistemology posed a contradiction: how could any researcher ever stand outside and regard the very structures that produce them to make such relativistic claims? Likewise Potter (1998) observed a problem in the proposition that all knowledge claims

have validity and no-one can be wrong was made by people who were determined their view on this should dominate. Sokal & Bricmont (1999) accused social constructionism of dismissing biological reality and therefore having ontological incoherence. As the field of social constructionist research has grown and diversified it was perhaps inevitable that ontological contradictions would appear. A number of authors have sought to make sense of the ontological parameters that may be now operating within this burgeoning body of theory. I would like to pay some attention to their propositions as this would both offer some clarity in terms of ontology and then allow me to describe my personal position within the current field.

Approaches to social constructionism. It is possible to group those who have sought to clarify the difficult issues involved in defining reality within social constructionism into three types of discourses. These are; whether the research aims to construct or deconstruct a particular reality; whether either individual or societal reality is foregrounded as a primary focus by the research; or which of the various definitions of the term reality has been favoured by researchers. I wish to describe each of these in turn.

Construction or deconstruction. The first involves categorising types of social constructionist research by what it aims to achieve in relation to either constructing or deconstructing realities. Danziger (1997) proposed the terms "light" (theory-building/propositional) and "dark" (deconstructive/critical) theory to differentiate the aims of the research. These terms were criticised for their unfortunate potential reference to racial terms (Burr, 2003)

Psychological or sociological. The second category examined the relationship between the truths of an individual in relation to their context versus how societal reality could become personal reality**.** This division proposed that problematic issues such as "the death of the subject" could be understood as an artifact of dividing up the academic

disciplines of psychology and sociology in the 20th Century. Burr (2003) argued these subject divisions used to apprehend the world did not necessarily correlate with real divisions *in the world*. As a psychologist, Burr was particularly concerned for the reality of the individual and so recommended a division between micro (the individual in relation to context) and macro (context in relation to the individual) as ways of describing the intention of research endeavours. Such division had similarities to the division between social constructionism and social constructivism where the focus is on societal discourses and how they affect the individual (macro/constructionism) and the latter focuses on the process whereby the individual makes sense of the social order around them (micro/constructivism). It has been argued that a micro approach allows a psychological self to exist but that the "Vocabulary of self can be challenged by exploring and elaborating non-dominant discourses" (Burr & Butt, 2000, p. 45).

Reality or construction. The third discourse has been around the underlying ontological assumptions in social constructionism, meaning what is claimed by the research as truth of reality. Mir and Watson (2001) proposed a division between radical social constructionism as anti-realist (there is nothing beyond the text) and moderate social constructionism as a form of critical-realism. Bashkar's (1993) proposal for critical-realism was that that some sense data is accurate to external objects or mechanisms but that these externals must be approached with critical reflexivity. Some social constructionists openly claim to embrace critical realism (Gergen, 2001). Similarly Liebrucks (2001) allowed a reality that transcends discourse in social constructionism, arguing that: "After all, their descriptions could not seem discrepant were they not supposed to be a description of the same matter" (p. 33). Whilst explicitly referring to a transcendent reality, social constructionists still maintain the construction of theory about that reality is always bound to social processes. Therefore theory cannot be taken as a direct mirror or measure of

reality separate from the theoriser and no models of reality can be “mind independent” (Tsang & Kwan, 2001, p. 716). In this proposition, moderate social constructionism is anti-positivist, but not anti-realist (Mir & Watson, 2001).

Burr (1998) suggested reality and constructionism had become positioned as opposites partly because the term reality is imprecise and can be interpreted in has a number of ways. She disputed that social constructionists had ever claimed reality was a figment of the imagination. Burr suggested this notion arose from a misreading of the scope of knowledge claimed in the original texts (Burr, 2003). In her reading, she identified three distinct dimensions of the ontological discourses involved in social constructionism as:

- Reality (as truth) versus falsehood
- Reality (as materiality) versus illusion
- Reality (as essence) versus construction (Burr, 2003, p. 101)

I personally find these divisions very helpful because it shows how easy it is to be imprecise when referring to reality. In my reading of the social constructionist literature the concept of reality as essence versus construction comes closest to my research interest. Mental health is subject area which involves both the social and biological. For me, in a social process such as art therapy, the issues are not whether biology is true or false, or material or illusionary. The issue is how a research approach can consider the mutual influence between the social and the biological even though each has different states of materiality and so require different tools to estimate their influence. The above literature suggests the history of mental health research has not been inspiring in this sense because it has often been so polarised. Psychological therapy, particularly those influenced as psychoanalytic have often been positioned as opposite to biological approaches, despite

this explicitly not being Freud's original intention or what neuroscience seems to suggest about how therapy works (Fonagy, 1999).

The issue of biological reality has been addressed within social constructionism. In describing their encounters with critics who bang their fists on tables or talk about the demise of a loved one and say "how can you say that is not real" (the so called "death and furniture" bottom-line argument against social constructionism) a number of authors make, to my reading convincing claims that the social constructionist position is not one of anti-realism, but of anti-essentialism (Edwards & Ashmore, 1995). Indeed, biological reality was addressed as real but interconnected with the social in the early texts. In arguing Berger and Luckman (1966) explicitly acknowledged: "The human organism is thus still developing biologically while already in a relationship to its environment from birth" (p. 66). A major aspect of that environment is the culture: "Homo sapiens is always homo socius" (p. 13). By way of example, they cite how worms or grubs are biologically edible to all human beings, but in one culture they will be enjoyed and in others they will induce vomiting.

The anti-essentialist argument therefore goes beyond the nature versus nurture debates in psychology. That framework retains an essentialist assumption of uni-directional *determination* from underlying structures such as genes or the brain, or by family or society (Harre 1983). The social constructionist is interested in exploring the *dialectic* between them, without assuming one has some transcendent essence which determines the other.

Social constructionism can claim it has generated theory specifically in relation to biological reality using this dialectic. Berger’s (1966) work on gender as an example did not deny a biological reality of sex differences existed between men and women, but argued that it did not explain everything we believed was real about gender. Likewise

Glaser and Strauss (1965) researched how those described as chronically ill made sense of their diagnosis and coped beyond the categories assigned to them. Further studies showed: "Illness is not so much the experience of symptoms as the reaction to those symptoms" (Hardey, 1998 p. 33). Social constructionists can likewise claim their approach has not just offered criticism of the biological model of health, but has contributed to the development of better clinical procedures used within the medical model. A social constructionist approach to pain management involved the inclusion of patients as well as clinicians in the development of protocols the use of analgesic medication (Kleinman, 1988). The reformulation of pain as an experience of the service user, centering on the need to feel in control (as gained from service user views), rather than pain as a purely biological phenomena led to the now widely used self-administration methods of medicating in the NHS.

Summary of social constructionism as an epistemology

To my reading, social constructionism offers a paradigm for understanding the power dynamic necessarily implicated in any truth claim about reality. The definition of an ontology which is anti-essentialist offers much needed clarity about what is meant by reality. History shows that it is where elites, from priesthoods to scientists, have claimed knowledge of universal and underlying causality repression has too often resulted. In the mental health field, essentialist claims have often led to ineffectual and harmful practices. The assumption that the social world is always implicated in the purpose of the research, the naming of subjects and the scope of claims made, is both an important political corrective and methodological discipline. I also think the anti-essentialist understanding of social constructionism untangles unhelpful one-to-one linking between epistemology and methodology. Whilst many studies in social constructionism have involved some form of text analysis, I find myself in agreement with Kenneth Gergen (1999, 2001) who argued

that this need not be so. It is not empirical methods, such as experiments or RCTs that are incompatible with social constructionism, but the universalistic truth claims that usually accompany them. In Gergen's view arguments about realism and construction can be viewed as different discourses to be used in different circumstances. Transparency about the purpose within the discourse allows both a moral and political framework for the researcher's action. In this sense Gergen's model of social constructionism is pragmatic and ethically sensitive. Different purposes require different methods, as languages or tools, but in using them the researchers intentions should be declared.

Abuse in science can be said to occur when findings become de-contextualised as essences from the researchers intention and the social phenomena they were produced in. In this spirit I should add that in my sumarising the above ideas in this way, I do not wish create an impression that my assumptions and beliefs about these social constructionism come solely from an academic appraisal of the literature. I recognise that I must similarly oblige myself to contextualise the present study. An epistemology describes the researcher's assumptions, beliefs and biases. Subjectivity in research has been described as: "The garment that cannot be removed" (Peshkin, 1988, p. 17). Rather than attempt to hide this I intend now to describe both my relationship to this epistemology and my intentions in the research within its framework.

Throughout the present study I kept a research diary. Research diaries have been described as tools for increasing “epistemological awareness” (Gerstle-Pepin & Patrizio, 2009, p. 300). Diary keeping has been used to link cognitive and affective processes which influence the research process (Gibbs, 2007). Research diaries have been used for bracketing, a process described as “a means of mitigating deleterious effect of preconceptions that may taint the research process” (Tufford & Newman, 2010, p. 10). In the social constructionist paradigm this is not used to seek purity of perception, but in the

post Heidegger (1962) sense that comprehending lived experience is an interpretive act which should be undertaken transparently. For this reason I wish to present extracts from that diary to outline how my own lived experiences which have formed my assumption, biases and beliefs as they relate to the present study.

A Personal Epistemology

Research is a difficult and laborious process, but it is undertaken on the assumption that structured enquiry is preferable to merely inventing an opinion for convenience. It would be hard to reconcile that view with an idea that one simply *chooses* an epistemology that seems to fit a particular research study. My view is that an epistemological position is not chosen, but discovered from reflection on lived experience. An epistemology is the researcher's way of making sense of their life. Mary Gergen (2001) described her epistemology as an internal dialogue with those who have shaped her life and who now act as "social ghosts" in her choices. I wish to bring my social ghosts to the fore and I do so by focusing on my transition from school to art college. By concentrating on this area I do not mean to suggest that other experiences had no influence on me. It is merely that this transition was one of such high contrasts for me that it offers a clear means of explaining my influences.

School failure or artist? My primary reflection about social constructionism is that I first encountered its basic tenets, not through the social sciences but as an aesthetic in the arts. This encounter happened most strikingly as I moved from school to art college. As a dyslexic child in the late 1960s, I was routinely extracted from the mainstream junior school classes to attend remedial sessions. I met a pleasant but disinterested elderly lady, perhaps a retired teacher, and read the same sentence in the same book over and over, week after week. I had no idea why I was there and my attitude was of having to just sit the ritual out. Because I failed the 11 plus exam I was sent to what was then called a

secondary modern school, these institutions being alternatives to grammar schools designed to equip non-academic children for manual work. My "fit" with the measures involved in the 11 plus exam must have been quite bad because I found I was allocated to the bottom class of that non-academic school. This categorisation had material consequences for those of us involved. To my knowledge none of my classmates' accessed further education. Most entered either low paid labour, the army or even prison. I alone went to university, joined the professions and became a consultant in the NHS. This was not achieved through some personal strength or epiphany, but through luck in accessing an alternative discourse of being "an artist". I do not now identify with the term artist in its reified use and am skeptical about those who use this language. However, as a school aged child I imbibed the term as though it identified some essence in me. It offered a crucial alternative to the representation of myself as stupid. Yet I cannot claim I made art with the intention of becoming an artist. I was a child who had trouble following verbal instructions in any of my classes. For me art was a way of externalising what I was thinking about. This helped me to consider it and seemed to stop the ideas and concepts from constantly "shimmering" as I termed it. I learned later that this is common experience of people who meet the criteria of dyslexia, but the term was never used in my schooling. My art was different from other children, perhaps for this reason. I found it won school prizes and I accepted the role of artist. By doing so this meant I was advised to go to an institution called art college.

Art colleges in the UK have an interesting history of offering non-academic and working class adolescents' access to higher education. Many art college graduates operated outside of the world visual arts, driving the countercultural upheavals of the 1960s through music, film and entrepreneurism. I am rather embarrassed to admit to my naivety on entering art college. I was unaware that art colleges encouraged students to question the

roles assigned to them by culture and instead encouraged them to find the means to interact with and shape the culture around them. I assumed I was still on some inevitable trajectory whereby I increased my technical artistic skills in order to complete the allocation to me of the role of artist, much like a coronation. What I met at art college had a profound and lasting effect because it was the opposite of the linear, and somnambulant, progression I had experienced in previous educational institutions.

Foucault (1971) suggested discourses were at their weakest at their junctures with other discourses. The jolting transition from the discourses of school artist to art college was an experience of reality change for me and is one of the foundational social ghosts that I converse with. My entry into art college in 1978 happened at a particular point in culture and history. The art college graduates who shaped the 1960s were now my tutors. This was also the midpoint in the cultural phenomenon of punk and it affected me and many in the generation that experienced it greatly. The musician and activist Billy Bragg often talks of having come through the "cleansing fire of punk" and I would agree with his assessment of it as a kind of discipline. Punk was one of many disputes about the social construction of values in culture and was very linked with art colleges. The term is vague. Punk is a name given to how ideas, aesthetics and countercultural movements coincided at that particular moment in post-war Britain. The distance of time makes it possible to argue that it ultimately had its roots in postmodernism. For example, punk challenged the prevailing distinctions between high and low art and the presumption that technical skill in music or art necessarily equated with artistic validity. At a point where countercultural figures were perceived as developing the very elites that they sought to challenge, the new generation was unwilling to accept that as a situation. As rock music became increasingly technical it positioned its audience as passive consumers of products from those elites. As a response, punk deliberately played music that its audience could immediately also make.

The ethos encouraged the self-starter. Anyone could reject the institutional roles offered to them and construct their own art. Granted, much of the music was hard to listen to, but I remember feeling it was the energy and impact that mattered.

In embracing punk I inadvertently found myself in a new discourse which ironically challenged many of assumptions that had brought me to art college. Although punk was part of a countercultural movement which predated it, (such as the long hair of hippies or garage bands in 1960s) it deconstructed many of the emblems of that previous generation. It did this explicitly in the punk accusation: "never trust a hippy." This kind of iconoclasm was not only musical but could be seen in the artwork of people such as Jamie Reid. Figure 1 shows an image of "God Save the Queen" made in the jubilee year on 1977.

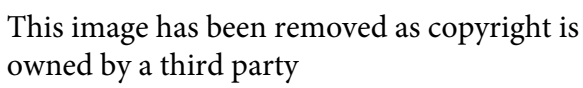

Figure 1. God Save the Queen, Jamie Reid, 1977

Reid was a situationalist, which was a group of intellectuals and artists interested in the idea of social alienation. Situationalism was concerned with "the spectacle", meaning mass media or the machinations of consumer society which it saw suppressing the authenticity of social relations through the consumption of commodities (Debord & John, 1959). The aim of situationalism was to interact with the spectacle via the construction of site-specific situations. These were disruptive events which attacked false consciousness in the hope of restating authentic, rather than capitalist, desires in everyday life. It is hard now to see just how provocative Reid's imagery was at the time of the Queen's jubilee. It is deliberately crude and constructed by means anyone could adopt, yet its power was

undeniable. This was in part because it addressed a specific situation, the jubilee that all were supposed to celebrate through buying memorabilia and the like. The imagery of God Save the Queen, and the crudeness of music then became emblematic of punk. In doing so the term quickly developed its own problems of reification and commercialisation. Reid's sequel to God Save the Queen encapsulates the deeper anti-essentialist ethos of what had been termed punk. Figure 2 shows Reid's follow up image "Never trust a punk."

Figure 2. Never Trust a Punk, Jamie Reid (1979)

Having assumed that I could now happily rely on a set of symbols which offended others, I found myself offended by this image. Yet unsettling as this was, I believe this was one of those moments where the anti-essentialist discourse acted on me. It sensitised me to the process Berger and Luckman (1966) referred to as language sedimentation, where symbols too far removed from the context they were developed in take on an empty quality. It interests me that language sedimentation appears to be able to be felt subjectively felt as a sensation of inauthenticity and hopelessness. I noticed how images drain of meaning, and become tired, old and without power as they lost context.

Emersion in punk was not something alongside art college, but a part of it. The study of art making within culture was a central aspect of the teaching at art college. This was evident in the method of "the crit", a learning process developed in the Bauhaus whereby artworks were discussed by students and tutors in a group in terms of formal integrity and cultural relevance. This was a difficult process which constantly challenged my

assumptions including those that brought me to art college, namely that a particular skill equated with a particular status as "an artist". I can recall in one "crit" where my newly dyed leopard skin hair became as much the subject of serious discussion as my artwork. For this reason I consider punk and as reflexive discipline. Those ideas first showed me the both power of context specific art interactions and the perishability of terms from one context to another. Experiencing this through the discourse of art college helped me to better read and therefore interact with the culture around me. I also became sensitised to how language, both verbal and visual, could not be considered a neutral conveyer of facts, but as a purposeful act of construction. I was able to abandon my ideas of technical realism in art (as in photographic levels of figurative representation). Instead I was helped to see that visual language is most authentic when it is congruous with its purpose..

In my own artwork I found it essential not to disguise the unreality of the means by which I arrived at images. In figure 3 below I was very interest in a sense of deluge and I used this as a starting point for an image which developed into an image which I felt was true, in the sense of authentic to the inner experience I was drawing on. I worked on this image until I felt that it achieved a sense rightness, this being the image had a level of isomorphy with my feeling. I notice many people who come to art therapy are very anxious about art making. They seem to have had the opposite school experience to me, where they were told they were "not artists." They seem oppressed by the idea that images should use photographic language in order to be valid. I feel I drawn on my experience of the type of image making in figure 3 to encourage them to engage with an intentional language in their art and not be paralysed by ideas of realism. I feel it helps that I have engaged in this type of art practice myself because I when I encourage, I do so with conviction of lived experience.

Figure 3. Authors image of a deluge, 2001

In reflecting on what I learnt at art college in at that particular cultural moment, I do not wish to grandly reify the past. Punk, for example, was never any kind of single entity. It was many things to many people. I am only attempting to describe what my exposure to that cultural discourse sensitised me to. In retrospect, many of the concerns I felt punk represented, such as playing in bands and challenging consumerism in popular culture seem narrow to me now. Yet I am unwilling to look contemptuously on my adolescent self because within the microcosm that concerned me then, I encountered important ideas about inclusion, cultural interaction, disruption and perishability which were transferable to wider areas of concern in my later life. I would restate here that I encountered these ideas as aesthetics before exploring them as philosophical and epistemological concepts. This observation is important, because as stated earlier, in my view an epistemology is not chosen but discovered through a reflection on what one is drawn to and how one acts in lived experience. My sense is because an epistemology is underpinned by beliefs assumptions and biases that often are hard to detect as one is actually engaged in a task such as research. What strikes me in reflecting in this manner is that particular

consistencies become clear in the in my choice of aesthetics, philosophical standpoints, career moves and subject areas for practice and research.

I find myself thinking of this period often as I continue as an art therapist in the mental health system. Social exclusion, stigma, denial of the means to interact with culture remain powerful forces for people diagnosed as mentally ill. Likewise when I reflect on the labeling I received at school I see parallels with the same process in mental health. I do not think people in my school wanted to oppress me by the way they categorised me, even though their actions nearly had disastrous consequences for me. I am struck though by the compliance with which we all reciprocated within our roles to create an empty institutionalised form of education. Academic streaming probably started with good intent but had moved too far from the original problem it aimed to solve. I did well at art college, and at graduation I won several national prizes and had my work brought by public galleries, but the anti-essentialist discourses I had experienced at art school made me mistrust the new role of artist that was offered to me by the art-world. I did not want to be part of that system, based around galleries, prizes and consumerism. I could not accept essentialist notions that one person is an artist and another is not. Yet, because I had been to art college, I now had a BA degree and that opened up a potential for social mobility far beyond that experienced by my class mates. The school was wrong in acting as if it had identified some essence in me that meant I could only undertake manual work. I seem to contribute to professional work reasonably well. But when I think back on all of this, I am struck by both how arbitrary the allocations of roles were and the reality of the effects on the people involved. These experiences convince me of the need to always consider the principles of the social construction of reality.

I am filled with gratitude for the help I received from those who gave me access to new discourses, but it is the precariousness of gaining that access causes me anxiety. It

could easily have been very different. My sense is that this anxiety is a cornerstone of why I continue to operate in a social constructionist epistemology. Whilst I have I have focused in some detail on my first real sense of how changing discourse changed social position I have also reflected that my anxiety about how this operates is reflected in many of the choices I have made in my career. My attraction to art therapy was that it questioned assumptions about that could have access to arts and the division between high and low art. My interest in mental health was that I saw that people who use services have often been trapped in limiting discourses given to them either from childhood or by the health care system. I recognise that nearly happened to me. My role in founding the art therapy practice research network aimed to challenge elitism in the profession by developing a forum for more practitioners to contribute to theory. When I look at my tenure as chair of the British Association of Art Therapists, I continued in the same vein. I document the battles I incurred in the research diary when I challenged who could act as a peer in the peer review processes for the International Journal of Art Therapy. When I became senior in my present NHS role, I developed a co-production research network with our service users. I could have progressed without taking these steps, but I am haunted by the social ghost of how arbitrary people's luck is (including my own) in how they access different discourses.

I would now like to extend this epistemological reflection to outline my choice of MBT as a practice framework and the use of observational research as a method in the present study.

Choice of the mentalization model. A more detailed literature review of mentalization is offered in chapter three, but at this point I wish to describe my personal connection with the practice. I found myself deeply uncomfortable with the group analytic principles I was initially trained in as an art therapist. The power relations involved in

claiming that the therapist can somehow read the unconscious mind of the service user (described in the art therapy literature review below in chapter two) and the labeling of unconscious processes as essences were simply unpalatable to me given my own poor experience with such labeling power at school. What attracted me to MBT was its basic premises, firstly that other people's minds are opaque and secondly that the therapist's stance must therefore be of: “Taking a genuine stance of not knowing and attempting to find out” (Bateman & Fonagy, 2004, p. 315). MBT is concerned with the processes of thought in the context of the here and now of the session and not with its insight in terms of thought content as a transcendent entity. For example MBT does not deal in essentialist propositions such as attributing a person's dreams to a pre-determined model of psychosexual development as might occur in classical psychoanalysis.

I also appreciate the lack of professional enclosure in MBT knowledge claims. Mentalizing is proposed as an everyday and common mechanism that all human beings use, and not as a discipline specific skill. Fonagy wittily encapsulated this idea at the British Association of Art Therapists Attachment and the Arts Conference when he presented a scientific looking slide depicting the human brain divided up into regions dedicated professional bodies (Figure 4). He simply described the image as "unlikely" (Fonagy, 2010).

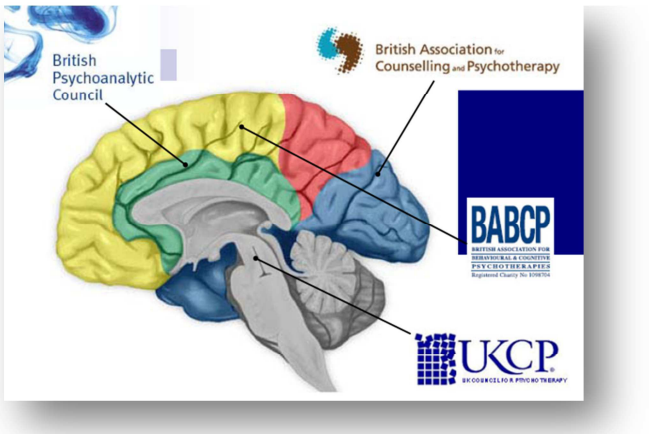

Figure 4. Fonagy's image of the professional enclosure of the brain

For me then, MBT offers the means to examine the process of social interaction. This targeted psychosocial intervention seems to me to better equip those who use our service to negotiate the various social words and cultures they encounter around them. It is not geared to insights which transcend the context of the session. Instead people are coming together in MBT to practice curiosity and collaboration as transferable skills.

Choice of observational methodology. It has interested me that as a visual profession, art therapy has used observational methods so little, particularly as art training offers good preparation for such research. It is my experience, structured observation is an important way of overcoming the problems of being overly influenced by received wisdom and institutionalised forms of knowledge. In describing my position on this I would like to return to my first encounters with observation at art college.

Another artistic discourse that influenced me was that developed by a group of artists around William Coldstream in the 1930 called the Euston Road School. At the point I entered art college, the anatomy lessons that had been a traditional circular activity for art students for hundreds of years were being phased out. The idea behind giving art students anatomy lessons was that knowledge of what was under the skin could be used to guide observational drawing of human beings. The Euston Road School of the 1930s approach was not interested in underneath explanations of the human form, but in the construction processes of observing it. My specific entry point to this discourse was the work of Euan Uglow. Figure 5 and 6 show two works by Uglow where the subject matter, person or object, is considered through a painstaking process of observation and cross referencing measurement. Those observational decisions are not hidden and remain as much a part of the finished piece as that which has been observed. Neither image claims to be an objective truth about a person or peach. The observer stays close to their data, so to speak, not straying into essentialist notions foreknowledge. For me the final result is

mesmerising. I think this is because I feel I am given a vivid sense of both the subject and the observer in relationship with each other at a specific moment.

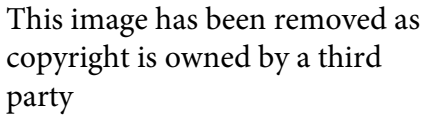

Figure 5. Head of A woman, 1971, Uwan Uglow

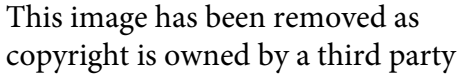

Figure 6. Peach 1971 Uwan Uglow

I encountered these concepts in my first week at art college. The tutors asked us to draw a simple object placed on the floor. We were allocated 90 minutes and asked to keep a still viewpoint for the exercise. Because I had become used to being considered the best artist at my school, I considered these conditions to be excessive. I *knew* how to draw and so representing this object was a trivial matter to me. I finished quickly. When the tutor

came to my easel, she drew her observations of the object from the same standpoint on top of my drawing. The comparison of the two drawings confronted me an irrefutable demonstration about how little I had understood the object in front of me. It gave me a vivid sense of the tutor's mental approach to the processes. Her view then changed how I saw the object and thereby changed the object itself: it really did look different. The tutor summarized that without carefully structured observation we merely impose what we think we see on the object. If we really observe the opposite happens and the object to shapes us. That moment had a profound and lasting effect on me. I noticed though that the pull to draw what assumes one knows is magnified many times when the subject was a person. Figure 7 shows a very early venture into this form of reflexive observational drawing. I still recall the strangeness of how the bridge of the nose met the eye socket and how vast the dome of the skull actually was. It just felt wrong as I measured and drew it, but it looked right when I drew it. Then, when I returned to the model, I saw relationships of form and space which had simply been invisible to me before.

Figure 7. Early observational drawing by the author, 1978

What struck me at the time of making this image was that when we did our "crit" of the images as a group, each picture had important differences. This was not because the

model was different but because the observation decisions and image construction was approached differently by each student. This is of course an observation deeply sympathetic to social constructionist thinking, even if I did not call it that at that time. This type of experience, repeated many times, made me curios about what observation, gathered through a range of views and purposeful decisions might illuminate about art therapy.

At the start of the present study I was mindful that Fonagy's caution that the discourse of psychoanalysis was too important to be left solely to psychoanalysts (Fonagy, 2000). My view is that the same concern could similarly be applied to art therapy. As I show in the art therapy literature review, most art therapy theory has been constructed by art therapists. It seemed to me that it was unlikely that all aspects of art therapy could be visible to any one party, including the art therapist. It seems reasonable to assume that as an art therapist, my practice habits, professional literature and culture have become so ubiquitous to me that they become unremarkable and eventually invisible. Liton (1936) argued that it often takes others to point out the cultural landscape we ourselves inhabit because: "The last thing a fish would notice is water" (p. 32).

In pursuing a description of art therapy through observational research, it was striking that most of the art therapists involved in the present study had never seen any art therapy apart from their own practice. Given art therapists have visual training as standard this is rather odd and I explore that further in chapter four. What I would say at this point is that these were experiences and factors led me to the conclusion that a social constructionist approach, with an emphasis on observation was overdue in art therapy. That conclusion then shaped the research decisions taken in the present study. I would like now to conclude by summarising my epistemological position.

Summary of my Epistemological Position

I have sensitivity to exclusion by descriptive terms because it happened to me as a child. I found it invaluable to gain the means to interact with the culture around me because it changed my position in it. I remain anxious that my access to the means of cultural interaction was highly arbitrary. I see art therapy as my way of interacting with the culture by reducing the arbitrariness of access to those means for others similarly facing marginalisation through the social construction of mental illness. My ontological assumptions have come from these lived experiences. I describe the net result of the above as my assuming a position of anti-essentialism in research.

In term of ontology I do not doubt a biology reality exists, but do not assume it must be positioned as causal. Instead, I am interested in considering the dialectic relationship between biology and the social. I doing so diagnostic terms are conceivably useable but only valid for explicitly circumscribed social processes and not for describing essences of people. Likewise I assume theory and terms produced by research have perishability because they are specific to the social purposes and contexts which are always implicated the research process. This does not make generalisation in theory impossible, but it does behove the researcher to consider important moral constraints on the universality of truth claims they make. In this sense I see my philosophical position as pragmatic, meaning I feel humans must be humble in the face of questions of reality and instead confine their criterion in determining meaning, truth or value through practical consequences of instrumental actions. In this respect I take a similar position to Hruby (2001) who argued: "The value of theory is not based on reality but on how useful they are to allow us to make predictions." (p. 21).

I do not agree that there is a one-to-one fit between research method and social constructionism, even though discourse analysis has been most often used. I value the way

discourse analysis has revealed the exploitative aspect of the act of diagnosis and the mental health system. I do not dismiss all aspects of that system as necessarily oppressive, partly because that would be making an essentialist claim. I see the suffering that people come to MBT with as real. Much of it pre-exists contact with mental health system and diagnosis, but I accept those processes can cause iatrogenic harm (including art therapy). However, I am in agreement with Willig (1999) who suggested discourse deconstruction is not enough because the challenge is not just account for why things are as they are but how they could be better. My position appears to be closest to Kenneth Gergen (2001) in this respect in considering different methods as tools or currency to be used within different discourses. In this paradigm even RCTs are conceivable within social constructionism, but with strict attention to context, terms, position of the researcher and the universality of their truth claims.

Burr (2003) identifies the epistemology of a person as a problem of identifying how to take up a moral or political position to inform ones action. This idea places special emphasis on labels and language use. Language cannot be taken as a transparent means of storing objectives truths. It describes the experience and intention of those who use it and as such language must be viewed as a form of social action (Saussure, 1974). It is many years since Whorfe (1941) observed that terms used set the preconditions for thought: "language is not a straightforward expression of thought but a person's native language determines the way they think and perceive the world" (p. 8). Having outlined some of the main the origins of my epistemological assumptions I now wish to focus on the purposes I use terms for within the present study.

Essentialism, Social Constructionism and Language.

One central area of labeling in language in science is that of taxonomy. Taxonomy has been described as that which facilitates communication between researchers so that

they can share accurately the description of the objects of study, retrieval of information, theoretical formulations used and predictions attempted (Blashfield & Dragans, 1976). It requires that: “Properties described in this manner must be sufficiently accessible so that persons other than the definer may independently measure or test them." (Shields & Rangarajan, 2013, p. 87). Taxonomy is a crucial aspect of operationalisation for many types of research. Operationalisation refers to a process that identifies specific, observable events or conditions such that any other researcher could independently measure or test for them (Shields & Rangarajan, 2013). Measurement of a non-tangible or not directly measurable phenomenon, as is often required in social sciences, has tended to involve researchers developing the means to measure one type of phenomena as indicated by another phenomena. For example, those aiming to research anger took proxy measures, such as vocal tones or facial expressions, to indicate the presence of anger (Shields & Rangarajan, 2013).

The concept of operationalisation has been controversial in the fields of psychiatry and psychology. Taxonomy which aims to identify a specific entity, such as an animal or a group of people, by a set of attributes which are necessary to its identity and function regardless of context is an essentialist proposition (Cartwright, 1968). The naming of essence of things can be seen to have generated controversy since Darwin (1855) who challenged religious doctrine by linking observable attributes with context as adaptations, rather than fixed or predetermined essences. In mental health critics argued psychiatric diagnostic manuals have used ambiguous taxonomy to identify the presence of mental disorders to the detriment of individuals and society (Frances, 2013). The social constructionist epistemology questions the validity of operationalisation beyond specified contexts and so my use of particular terms in the present study requires some explanation.

The present study explores video edited sequences of mentalization-based art therapy groups. I identified two groups of persons involved in the groups, namely service users who have received a diagnosis of personality disorder and art therapists. I allocated these terms in relation to the role each person took in relation to the art therapy task. These terms were not used as essences and were not intended to apply beyond that context. That said, that I acknowledge that the art therapy groups occurred within a wider social context of the UK mental health system where these same terms may have been employed quite differently. I would like to define my use of each of these terms, beginning with the art therapist because I then wish to devote some space to the complexities involved in the use of the terms service user and borderline personality disorder.

Art therapist. Art therapists are named by virtue of having undertaken training in art therapy and having been employed by the NHS for that purpose. This is a context specific role. In this setting they adhere to both employment terms and conditions and the regulations of the Health Care and Practice Professions standards, and are in the group is to offer a particular type of help. I do not claim they possess some kind of essence different from the service user.

Service user. The term service user is likewise used to denote people who are present at that moment in the art therapy sessions as users of the National Health Service. Just like the art therapist role, I did not consider the term to be applicable outside of that specific context and would consider its wider use as an essence to be stigmatising. The particular service used by these persons is designed for people who meet the criteria for borderline personality disorder. Because this is such a controversial diagnosis I recognise that in using the term I risk denoting those persons as somehow essentially different. For this reason I wish to outline those controversies and detail my context specific use of the term within the present study.

Borderline personality disorder. The International Classification of Mental and Behavioural Disorders (ICD-10, 2010) defined personality disorder as:

> "A severe disturbance in the characterological condition and behavioural tendencies of the individual, usually involving several areas of the personality, and nearly always associated with considerable personal and social disruption." (p. 252)

Within this term, ICD-10 identifies 10 sub-categories of personality disorder. Alternatively, The DSM-IV identified nine sub-categories and also employed a clustering system to group conditions by characteristics:

- Cluster A (odd or eccentric types): paranoid, schizoid, schizotypal
- Cluster B (dramatic, emotional or eccentric types): histrionic, narcissistic, antisocial and borderline
- Cluster C (anxious and fearful types): obsessive compulsive, avoidant and dependent

Located within cluster B, borderline personality disorder was characterised by unstable mood and sense of self, with impaired interpersonal functioning and preoccupation about potential abandonment from significant others.

The diagnostic classification of borderline personality disorder remains contentious as a means of establishing a reliable or useful clinical diagnosis (Widiger & Samuel, 2006). The original use of the term "borderline" was coined to describe what was originally seen as overlapping states of psychosis and neurosis, because transient psychotic-like states were observed in those with the condition. By the mid 1970's this idea was being discredited: "This waste basket term really said more about our ignorance on the subject than what was wrong with the patient" (Masterson, 1976, p. 3). This understanding of the concept was later dropped, even though the term borderline remained.

Criticisms of the concept were voiced by feminists who noted a male gender bias in their study of how clinicians formulate models of adult female maturity (Bjorklund, 2006; Broverman, Broverman, Clarkson, Rosenkrantz & Vogel, 1970; Burt, 1996). Eastwood (2012) noted that whilst 75 percent of those diagnosed with borderline personality disorder were female, the DSM-III (1980) did not include any female authors in its formulation. The most recent version in 2013 significantly was revised due to the inclusion of female and minorities involved in its formulation process.

In 2003 the National Institute for Mental Health England (NIMHE) issued policy implementation guidance and funding for the development of services for people with personality disorder. The guidance was issued noting that whilst the condition was common (estimating, cautiously, that 10-13 percent of the adult population and between 36-67 percent of adult psychiatric population meet diagnostic criteria), those suffering the condition were often poorly served by the NHS. Many were left to the margins of care and relied on accident and emergency services or treatment via inappropriate acute psychiatric ward admissions. The authors of the guidance admitted the condition was poorly understood by clinicians and the behaviour of those with personality disorder evoked high levels of anxiety in professionals. A distinguishing feature of the diagnosis, in addition to other "mental illnesses", is that no medication has been identified to treat it (Bateman & Fonagy, 2006). This challenges the discourse of evidence based medicine as the warranting voice for treatment and perhaps explains something about their exclusion from NHS services. As a service user stated: “Personality disorder is the label given to the service users psychiatrists dislike." (NIMHE, 2003, p. 14).

Many of the labeling problems involved in mental illness diagnosis have been outlined above, but the term personality disorder appears to have particular issues in this respect. Where a diagnosis of mental illness tends to reinforce the strange difference and

otherness of some people in society (Beresford, 2002) the fact that the term "personality" is used constructs a discourse of a disorder which renders individuals as essentially different from other people (Wright, Haigh, & McKeown, 2007). Some evidence indicates that when interviewed many service users preferred the diagnosis of bi-polar disorder to describe their mood fluctuation, even when their experience did not correlate with that diagnostic criteria. When probed this was because service users feared locating the problem in the personality, which they perceived as communicating that it was their fault (Richardson & Tracy, 2014). Likewise, in reflecting on their own experience of receiving the diagnosis, Morgan, Knight, Bagwash and Thompson (2012) experienced the location of disorder in the personality exacerbated feelings of poor self-worth. Link, Cullen, Struening and Shrouf (1998) proposed that diagnosis of personality disorder created a negative cycle where categorisation of individuals leads to their expecting rejection which results their use of defensive strategies that confirm that expectation. The end result is a self-fulfilling prophecy of rejection mutually enacted (Aviram, Brodsky & Stanley, 2006).

Whilst acknowledging the difficulties of labeling in the condition as an essence, I would argue that it cannot be assumed that it is the process of grouping people together by difficulty that causes harm. For example studies which examine views from service users about the diagnostic process in borderline personality disorder are mixed, rather uniformly negative. Many found the diagnosis reduced feelings of isolation because it brought them into contact with others who had experienced what they assumed only they had experienced (Morgan, Knight, Bagwash and Thompson, 2012). Some studies indicate that how the diagnosis is given by the clinician, rather than the terms used, determines the problematic outcome (Richardson & Tracy, 2014). In an interview of 28 participants, Bilderbeck, Sanders, Price and Goodwin (2014) found that where service users were given comprehensive information, time and respect, they were often greatly relieved by the term.

The diagnosis gave some people a sense of validation and recognition that their difficulties were not simply personal choices. Bateman (2007) noted that evidence is mounting that service user psycho-education around the diagnosis of personality disorder improves treatment outcomes because it equals aspects of the alliance around knowledge and creates a shared focus between service user and professional. Bilderbeck Sanders, Price and Goodwin (2014) likewise recommended that psychiatrist should favour discussion of difficulties within the current understanding of personality disorder and "not assume a primary diagnosis is sought" (p. 238).

It seems pertinent to ask whether it can be legitimate to use the term borderline personality disorder within a social constructionist paradigm? I accept that on far too many occasions the use of the term borderline personality disorder has been used to describe core essences of the person in a discriminatorily fashion. However, I would not reify that observation by extending some kind of inherent power to the term borderline personality disorder as a descriptor of a set of experiences people have. I believe if it is used with circumspection, it does not necessarily have to become an essentialist enterprise. The term offers potential for research if is used as a grouping for the explicit purpose of asking research questions. After all, the studies above which identified the stigma involved in the diagnosis had done so by using the term borderline personality disorder as a grouping. In my own experience as an art therapist, the service users I meet in clinical practice always describe difficulties long predating contact with mental health services where they received that diagnostic term. Even though those services can respond unhelpfully or make matters worse, those persons come to the NHS seeking help for some of the most disturbing experiences imaginable.

Use of terms by Emergence. Perhaps another important point of view that should be considered in the issue of the use of the term borderline personality disorder is that of

service user led Community Interest Company that took part in the present study. My connection with Emergence was through their predecessor group called Personality Plus which was very involved with arts based recovery approaches. Like Personality Plus, Emergence explicitly bases its organisation around the term personality disorder and I have discussed their use of term on numerous occasions. They have told me they very much recognise the limitations of the term, have lived with the very real stigma it confers and accept some people would choose not to identify with term even if they identify with the issues it refers to. They argue that even as an imperfect term, it is currently all we have to describe a community of people who have had unusual experiences. Many have been deeply relieved to find they are not alone in experiencing difficulties which many in the wider community do not. One member of Emergence told me of his relief at receiving the description of borderline personality disorder, saying he thought psychiatrists were going to have to name a new condition after him because he had the impression that he was the only person ever to have experienced what he had. Although humorous, this describes a terrifying level of isolation on top of the experiences he found he was having. The blogger who names herself Lucy made a similar point on her commentary on her lived experience: "I would love non-borderliners to somehow to be able to taste this foreign territory from inside" (retrieved from http:www.my boderlinelife.co.uk, 4th June 2014).

Another reason Emergence argue for the current use of the term is that it gives them a voice to interact with the evidence based paradigm of the NHS. A number of Emergence members are passionate researchers. One member sent me the image below (Figure 8) which she felt represented her aspiration to integrate the reality of the lived experience of people diagnosed with borderline personality disorder with advances in the science which aim to understand it. This image is of the Oxytocin molecule tattooed over an arm which has scars from self-harm. She argued that collaboration in research moved her from solely

being a passive receiver of services to an active participant in the discourse of treatment itself.

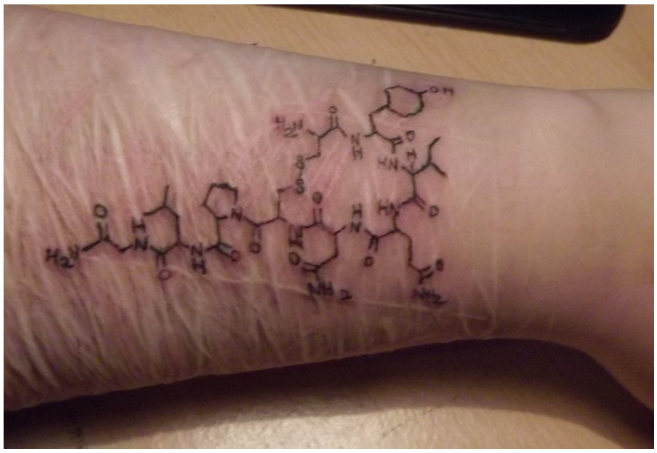

Figure 8. A tattoo of the Oxytocin molecule over a scarred arm.

Personal relationship to terms. Perhaps another important reason why I choose to focus on those diagnosed with borderline personality disorder and to use the term comes from my own experience as an art therapist. I noted in my research diary that that to work as an art therapist in services for people who have been diagnosed with borderline personality disorder is to work with human suffering as a raw material. However, the force of this powerfully affecting work experience is not always amenable to words. It is a common practice for art therapists to process their own thoughts and feelings after sessions through image-making. I wish to present one of my images because I feel it represents something of that experience which has driven my interest in the present study. Figure 9 was made after a particularly powerful and difficult art therapy group. The session had involved graphic descriptions of self-harm, with high levels of fear and defensiveness amongst those in the session. My reflections on this piece were that it referenced trauma in both bodies and minds. Reflecting on that helped me to become aware that it was when the fear became too great in the group that was when the interpersonal exchanges became fractured. We had all spoken over each other, struggled to think about the intentions of others and keep a focus on the task of the therapy. The image

encapsulated that fragmenting quality for me, with numerous disparate elements swirling in a distracting and unsettling way.

Figure 9. Processing image made by the author following an art therapy session.

I present this image because it is the intolerability of that suffering for the actual people experiencing it that drives my interest in using research to improve my clinical practice as an art therapist. These feelings commonly occur in clinical sessions I undertake with people who have been diagnosed with borderline personality disorder in a way they do not when I work with other populations. I do not wish to overstretch this observation to any kind of presumption that my personal feeling could be used to identify some unique disease entity. Instead, making this image helped me to articulate that I did not wish to discount the particularity of that reaction either, because it is a part of what has driven me to ask questions about this area via undertaking research. I do not see this as incompatible with social constructionism

Summary of Use of Terms within a Social Constructionist Epistemology

My reading of social constructionism convinces me that human beings must not be seduced by their own theorising and remain vigilant to the dangers of over-extending ideas into claims about essences or universalities. As Eisenberg (1988) said in his introduction to the social construction of mental illness:

> "I do not in the least imply disease would not exist in the world if men did not recognise them ... but our observations do shape the way we construct them. The way we formulate the diagnosis, the way society responds does have consequences for the course and outcome." (p. 1)

In the context of the present study then, I use the term borderline personality disorder to describe a group of people who identified they were experiencing a set of problems who then voluntarily sought help from the NHS. As part of their service use they were given a diagnosis and then allocated to specific treatment approaches (MBT) where they encountered others who experienced similar problems. I would state that for this research I did not take the additional step of teleologically assuming our NHS grouping for the purpose of treatment correlated with a disease etiology. My view is that mental health research is not yet sophisticated enough to understand what causes what we currently describe as borderline personality disorder or even if this is a single entity. This statement indicates that I use the term borderline personality disorder as intrinsically linked with two limited purposes, namely mentalization-based therapy and research. I would state though that so like many, I wait impatiently for a better, non-diagnostic term to become available.

With this epistemology in mind, I now wish to begin the specific study I undertook as part of a PhD. I begin with a literature review which was undertaken in preparation for that main study.

Chapter Two. Describing Art Therapy: A Review of the Literature

This chapter begins the literature review section. It aims to outline how the development of taxonomy for clinical practice might be viewed as an essential step in developing the effectiveness of art therapy through a larger research strategy. Whilst effectiveness is often assessed using methods such as randomised control trials (RCTs), the preparatory issues involved in operationalising psychological therapy practice for the purpose of effectiveness research are considerable. I then examined the effectiveness studies undertaken in art therapy to date with a particular focus on the operationalisation processes they undertook. I then move on to examine art therapy literature beyond the effectiveness studies to see if other types of papers might offer practice descriptions. Because the quantity of art therapy literature was quite vast, I limited my focus specifically to two domains. First, to features which might be considered unique to art therapy, this resulted in a review of the triangular relationship that exists between art therapist service user and artwork. Second, to the area of group art therapy because this was the treatment approach used in the main study. I gave particular attention to what art therapy group theorists said about their practice in relation to the triangular relationship

I wish now to describe the search strategy methodology I used in this chapter and the following two.

Over-arching Search Strategy.

At all stages the following databases were searched through Canterbury Christ Church University's e-library search facility. These were: Applied Social Sciences Index; British Humanities Index; British Medical Journal; Cumulative Index to Nursing and Allied Health; Directory of Social Sciences; PsychInfo; PubMed; MedLine; Sage online; and Science direct. This allowed a Boolean search approach to combine, expand or

exclude specific terms to be applied to the databases. I describe the specific search terms used terms at the start of each relevant section.

In addition I consulted literature that had not been peer-reviewed or did not feature on research databases, termed “grey literature” (Bolderston, 2008, p. 88). These were conference proceedings, news-briefings, committee reports and articles and memorandum from the British Association of Art Therapists and the Health and Care Professions Council. No limits were placed on age or language of either database retrieved, peer reviewed or grey literature. In all cases throughout the literature review I undertook a manual search approach to the three major art therapy journals, namely the: *Arts in Psychotherapy*; *International Journal of Art Therapy (previously known as Inscape);* and *American Journal of Art Therapy.* This was because the *International Journal of Art Therapy* only adopted a key word system in 2008 and only appeared in any search engine from 2011. Similarly the *American Journal of Art Therapy* adopted key words in 2001. Consequently I undertook a manual search from the British Association of Art Therapists library of all abstracts from these three art therapy journals and I traced literature back to 1980, which is the point from which the journals were consistently available. This secondary strategy was highly productive with regards to all literature review questions because many of the items that I was searching for appeared in the abstracts but were not named as key words.

Because the search strategy was international, the terms used to denote the individual receiving an art therapy intervention varied widely in reflection of the respective cultures of care. For the sake of clarity, throughout the present study when not using direct quotations, the term “service user” is applied to denote those receiving treatment from a mental health professional, which otherwise had been variously termed patient, consumer, customer, or analysand in the original texts.

Search strategy for chapter two. The search question was: How has art therapy been defined? As part of this question I particularly focused on claims of unique features of art therapy in relation to group approaches. The search terms used were: “art therapy”; “art psychotherapy”; “creative therapies” and “arts therapies; which were each combined with the terms: “definition”; “description”; “history”; “unique features”; and “defining features”. Following the results from this initial search it became clear that the triangular relationship was often cited as a uniquely defining feature of art therapy. Therefore a secondary search question was developed which was: "How do art therapists describe their practice in the triangular relationship?" As stated above, because the present study was concerned with group work, particular attention was paid to this mode of treatment. A search was then undertaken using the terms: “triangular relationship”; “group approaches”; and “group-work” in combination with the above. These searches revealed English language only results. No limit was placed on language or on the age of any literature because art therapy may have been defined by a process of historical precedents. Because such a large proportion the literature came from “grey” sources it was not categorized by the strengths and weakness of its research methodology but on its relevance to the search question. These searches revealed fifty eight relevant papers, all of which were in English. The literature was appraised on the research approach used and the level of description of art therapy practice offered.

Why Describing Therapist Action Matters

The British Association of Art Therapists (BAAT) has prioritised the use of research to increase the effectiveness of art therapy (BAAT AGM 2011). As has been discussed in chapter one, the National Institute for Clinical Excellence consider Randomised Control Trials (RCT) to be the "gold standard" for measuring effectiveness. Even in this paradigm, the validity of such trials depends on the clarity of the researcher’s hypotheses so that all

are clear from the start as to the exact nature of the intervention being tested (Wood, 2013). Because psychological therapies use human interaction to address human distress, the employment of RCT methodology requires a considerable amount of preparation to achieve such hypothetical clarity. Given the complex human nature of the subject, clear taxonomical definitions of what is being tested (which can be identified by a range of researchers beyond the definer) are particularly important. This kind of theory building requires significant attention is given to the development of explicit propositions about how a mechanism of action (therapy practice) influences a phenomenon (human distress): "(...) the mechanism of action can only be understood only when applied to an explanatory model of the condition treated" (Kazdin, 2004, p. 923). Forming propositions of actions in relation to condition treated supports two significant areas of operationalisation, namely finding measures to estimate treatment fidelity and outcome. This difficult pre-trial task is essentially about bridging the transmission gap between principles and how they are enacted in practice. Important work has begun in psychoanalytic research in this area because it was acknowledged that: "Clinical technique is not logically entailed in psychoanalytic theory." (Fonagy, 2006, p. 36). When the same criterion is applied to art therapy it seems reasonable to assume the demands of theory building for outcome research may have (historically) been underestimated by art therapists.

Two systematic reviews of art therapy outcome research identified 52 studies from the American, Canadian and British art therapy journals up to 2007 (Reynolds, Nabors & Quinlan, 2000; Slayton, D'Archer & Kaplan, 2011). Whilst most studies claimed to show positive benefits, Reynolds, Nabors & Quinlan's (2000) observation that "Many studies reviewed did not provide detailed description of the art therapy intervention" (p. 208) can be said to apply to the whole set of studies in both reviews. Since these reviews the largest art therapy RCT to date, the Multi-Centre Study of Art Therapy in Schizophrenia

(MATISSE), designed to test the effectiveness of art therapy in improving global functioning of people with schizophrenia, concluded that: “Referring people with established schizophrenia to group art therapy as delivered in this trial did not improve global functioning, mental health or other related outcomes." (Crawford et al., 2012, p. 334). However, establishing what was actually delivered in the trial has proved controversial. Fortunately, the debates about MATISSE have been documented and this body of literature usefully offers the opportunity to consider the state of readiness of art therapy theory for such research.

It had been observed that very little definition of the practice tested in MATISSE had been published and this posed threats to the validity of the trail's claim (Wood, 2014; Holttum & Huet, 2014). Patterson, Waller, Killespy and Crawford (2015) claimed to rectify that by publishing their account of the practice tested. The authors described that the trial began with Waller's (1993) model of interactive group art therapy but it became clear during the trail that art therapists were not adhering to that practice. The interactive group model was abandoned and art therapists were permitted to practice as they would usually e.g. idiosyncratic practice. The trial’s continuance was justified on the argument that this better represented art therapy practice in naturalistic settings and that robust monitoring, by experts, was in put in place. The experts claimed practice parameters were compliant with the BAAT public definition of art therapy, which was as follows: "A form of psychotherapy that uses art media as its primary mode of expression and communication ... art is not used as a diagnostic tool but as a medium to address emotional issues which may be confusing and distressing." As chair of BAAT at the point that definition was produced, I was aware that it had a very specific purpose which was entirely distinct from its use in MATISSE. The definition was carefully written as introduction to the profession for a lay, not an expert, audience. It was a promotional

headline and not a theoretical proposition for defining practice. In fact its purpose was to deliberately be as non-specific as possible and avoid defining any kind of art therapy approach so as to not exclude any form of art therapy. For these reasons I argue it must be the weakest form of theory to use as a measure for fidelity in an RCT of this caliber.

A third phase of practice definition appears to have been instigated after the trail had begun. Interview data gathered during the trail data were analysed and three models were retrospectively inferred, namely the modified studio model, the phased group model and potentially interactive model. This particular combination of quantitative and qualitative approach in the RCT was justified as "pragmatic" on the basis that the trail involved a complex intervention as defined by Medical Research Council. Patterson, Waller, Killespy and Crawford (2015) argued that this research decision was valid because there was a difficulty in identifying mechanisms of change in art therapy as a multi-component intervention. It could be argued though that this difficulty was not due to some inherent property of art therapy, but because we as art therapist had not attempted to identify those mechanisms in the way we constructed our theory. Bateman (2007) has been critical of the use of the Medical Research Council definition as a loophole for poor theory building prior to RCTs, summarising: "In other words, from a cynical perspective, if you don't really know what is happening within an intervention or you haven't thought through your intervention carefully enough, then it is a complex intervention!" (p. 250).

The present study is concerned with how a broad research strategy, which includes RCTs, might offer valuable insights into art therapy practice. Given its size and the subsequent debates it has fuelled, at this point it is important to ask what learning is possible from MATISSE. Putting aside a question about defining practice *after* the RCT has started (and how difficult it would be to justify that in the pharmaceutical domain), it is hard to agree with the assertion by Patterson, Waller, Killespy and Crawford (2015) that

practice in MATTISE has been defined. Questions remain: Did the trial test one model (Waller, 1993), no model (idiosyncratic practice) or three (modified studio, phased group, and potentially interactive)? Given no process was in place to trace the progress of any single approach used, how can we learn which was more successful so as to improve art therapy? Therefore it seems logical move from the trail's outcomes to look instead at the pre-trial preparation of theory. This moves the focus away MATISSE and back into the art therapy profession. In this respect I believe Sue Patterson's grounded theory research is of immense value to art therapists. Patterson's use of grounded theory, with multiple data sources, including interviews of 110 art therapists (approximate to 5% of the UK profession) offers a mirror to consider the state of art therapy theory in the UK at 2015. The models she identified do include some descriptions of practice, with some potential for identifying propositions but are not yet developed beyond description of structure and values. Her interviews also show how hard it was for art therapists to draw on existing theory to inform or describe practice (Patterson, Crawford, Ainsworth, & Waller, 2011). However, the conclusion that: "Given art therapists' contention that the infinite variability is a key strength of the approach, attempts at further prescription may be unproductive" (Patterson, Waller, Killespy and Crawford, 2015, p. 36) is to my reading both reasonable based on the study's interview data, but also a council of despair which needs opposing. As an art therapist not interviewed in her study, I raise both a methodological and ethical objection. First, why would it be assumed that the construction of art therapy theory could not identify mechanisms action before it has been tried? Second, claiming a right to practice in an infinite variability has power implications: just because the title art therapist is legally protected is that a license to do anything within that title's defined scope? Given the level of human suffering that those who seeking help from art therapy experience, and

the mounting evidence about beneficial and harmful practices in related fields (Lillenfied, 2007), I feel those involved in art therapy research have to offer better.

The above then represents the context for the present study. A lack of clarity in the definition of art therapy practice has, and I argue always will, pose threats to the validity of art therapy research. For this reason, I have chosen to focus on defining that art therapy practice as I see it as an important foundation for future research. To that end I now start with a review of the literature that has bearing on the art therapy within the mentalization-based model for people who have been diagnosed with borderline personality disorder. Before describing what I found in the literature, I begin by outlining the methodology I used to locate relevant texts.

How has Art Therapy been Defined?

Adrian Hill coined the term “art therapy” in 1938 as “all that goes on under the name of art in hospitals." (Lydiatt, 1971, p. 12). Given his term predated the National Health Service (1948) and the Community Care Act (1990) the term “hospital” effectively encapsulated all mental health treatment. Evidence existed of art activities in hospitals long before the term art therapy (Thomson, 1989). Hill’s use of the term grouped together a very disparate set of existing practices and many of these would now be classified as “participative arts” (Hacking, Secker, Kent, Shenton, & Spandler 2006) or “arts and health” (Dileo & Bradt, 2009). Hogan (2001) viewed Hill’s description as referring to an emerging form of art-based occupational therapy and not reflecting art therapy as it was later understood.

After seven decades the field of arts and mental health had diversified. The original meaning of the term art therapy was so broad that it offered little to define a discrete practice for research purposes. Arts and health research studies undertaken by the Department of Media Culture and Sport and the Arts Council (Staricoff, 2004) and the

Department of Media Culture and Sport (Secker, Hacking, Spandler, Kent & Shenton, 2007) specifically excluded art therapy. Likewise art therapy research excluded arts and health projects (Gilroy, 2006).

The differentiation of art therapy in these research studies was determined by the definition of the *practitioner* rather than the description of the *practice* itself. This appeared to represent a dominant trend in art therapy where practice description was neglected relative to definition of the practitioner. In 1997 practitioner titles "art therapist" and "art psychotherapist" became protected titles under law through the Health Professions Council and were determined by training of the practitioner rather than any description of practice (Waller, 2004). Thorne criticised this strategy: “If [art therapists] are to survive we need to be able to decide what it is we think we are doing. I’ve heard it said that art therapy is the work done by art therapists. This is not good enough.” (Thorne, 2011, p. 26). A similar criticism was made of other forms of psychological therapy in the gibe that: “Psychotherapy is an undefined technique for which rigorous training is recommended." (Raimy, 1950, p. 22).

Attempts have been made to define art therapy practice from the literature. Karkou and Sanderson (2006) undertook a combined systematic review of the literature from the journal, *International Journal of Art Therapy*, from the period 1990 to 2005 with interviews from the most prominent published art therapists. The study highlighted that art therapist increasingly defined art therapy practice through psychoanalytic theory and concluded that art therapists defined the therapeutic relationship as the key concept. The psychoanalytic model of art therapy placed the relationship between therapist and servicer as the primary vehicle for re-enacting and working through of the concept of the transference. Transference represented patterns of relating and perceiving the world shaped by past experience. The psychoanalytic approach sought to help free the service

user from the grip of the past by developing insight into their unconscious transference as it was re-enacted in the therapeutic relationship when the service user made art in the presence of the art therapist (Naumberg, 1950). The model proposed that how the therapist felt (counter-transference) within the relationship was part of an unconscious communication of transference from the service user. The emerging dominance of psychoanalytic concepts in art therapy in the UK was replicated in the USA (Lachman-Chapin, 2002; Wadeson, 2002).

Early writers observed that the strategy of combining psychoanalytic concepts with the practice of art making to define art therapy posed potential threats to articulating its unique features. In her seminal paper, Irene Champernowne (1971) anticipated that defining one practice in terms of another practice (e.g. art as therapy or therapy as art) risked merely inducting one into the other. A number of arts therapists likewise called for the theorization of arts therapies to be drawn from language and concepts that originated uniquely from the arts therapies practice (Jones, 1996; Karkou & Sanderson, 2006; Kossolapow, Scoble, & Waller, 2001; Meekums, 2002).

The literature review revealed that the most promising candidate for an aspect of art therapy which has been defined in its own terms concerned the art therapy triangular relationship. The triangular relationship concept referred to the three nodes that exist in the art therapy matrix. At its most basic level the triangular relationship includes a service user, an artwork and an art therapist. It was arguably unique to art therapy because it listed the fundamental elements at play in an art therapy session. Therefore, I wish to focus on this literature to examine what it revealed about descriptions of practice.

The triangular relationship as a defining feature of art therapy. The first reference to a triangular relationship in art therapy was by Wood (1984). In describing her work with children within a psychoanalytic framework she referred to art therapy as a

“triangular space” (Wood, 1984, p. 68). Wood claimed that merely making art, without an integrated human relationship could not have the same therapeutic effect.

> “Whatever the overburdening factors, the explorative dialogue with the picture fails; it becomes a closed reflective system, even within a supportive environment. Painting in the presence of the therapist alters the intention and the dynamic balance; dyad becomes triad. This may be described as a triangulation around the potential space.” (p. 68)

Case (1990) claimed the triangular relationship: “(...) challenges the whole notion of the “healing arts”; the work of art therapy being the process of making and puts emphasis on the verbal exploration of the images within the therapeutic relationship." (p. 20). Case cited the frequency with which children referred to the picture they drew (but where the therapist merely sat with them not drawing as “(...) the picture we did together" as evidence that the artwork was perceived by the service user to be embedded in the human relationship (p. 22).

Schaverien (1992) developed an “analytic art therapy” model based on a case study of one patient, Schaverien attempted to position her approach within the three possible ways that art therapists could strike a balance between art-making and therapeutic relationship:

1. “Art therapy (art focused)
2. Art psychotherapy (therapeutic relationship focused)
3. Analytic art therapy (art and therapeutic relationship focused)." (p. 44)

Skaife (1995) criticised Schaverien’s construct by suggesting that art therapists moved between all of three relationships within any single treatment as a key strength of their approach.

Wood suggested the permanence of the artwork as a material object could act as a useful anchor in the transient nature of the human to human interaction in the therapy relationship: “As the precipitate of the interaction between inner and outer worlds, the painting becomes a third world, unchanged by attitudes, time, or the distortions of memory, yet different aspects meaning and relating can be discovered on different occasions." (Wood, 1984, p. 64). Citing Camic’s (2010) observation whilst that the interaction with objects play a crucial role in human development their role in therapy had been underexplored, they suggested this model may indicate potential for practice congruent theory building.

Wood (1990) offered a criticism of a purely psychoanalytic approach to the triangular relationship in noting that the inclusion of art in therapy created a tension in the original verbal model. She argued that the relationship between service user and their artwork required a separate relationship description from the traditional service user and art therapist therapeutic relationship. The relationship to their art was described as part of a service user’s own internal dialogue and should not just be viewed as creating “messages for the therapist” (Wood, 1990, p. 11). Case (1990) stressed that there were phenomena occurring in the triangular relationship other than communicating to the therapist or putting words to pictures. She highlighted the act of just looking silently at the image, referred to as the aesthetic experience. Likewise Learmonth (1994) and Case (1996) emphasised the value of silent witnessing of artwork by the service user and art therapist.

Damerell (1999) questioned why art therapists had not linked practice to developmental psychology and attachment theory: “An important opportunity to recognise that the triangular relationship involves two pairs of eyes on a target object has been missed.” (Damerell, 1999, p. 45). Isserow (2013) linked the potential for therapeutically reducing face to face intimacy in art therapy with the infant observational research

conducted by developmental psychologist Trevarthen (1979; 1980; & 2004): “Within any art therapy session it may be useful to consider if and when the client is predominantly engaged with the art materials/art object or with the therapist, as well as moments when the client can be in relation to all components of the art therapeutic relationship." (Isserow, 2013, p. 130). Isserow (2008) explored how, rather than accepting that the coordinating and sharing of affect around a third object was a given, the work of Bakeman and Adamson (1984) helped to show this capability was premised on a series of profound developmental milestones. Isserow’s two case studies attempted to demonstrate that the process of “looking together” might actively aid the development of the ability to appreciate the contents of the service user’s own mind in relation to the mind of the therapist in relation to a third object, a process described as “mentalization” (described in detail in chapter three). Isserow suggested that the looking together process drew on Trevarthen’s (1980) concept of intersubjectivity, originating from his observations of infants. In this model, intersubjectivity had two phases: primary intersubjectivity which involved face to face engagement with the mother; and secondary intersubjectivity which involved sharing attention with the mother on a third object. Isserow offered Hobson’s (2004) diagram (Figure 10) to represent these distinctions.

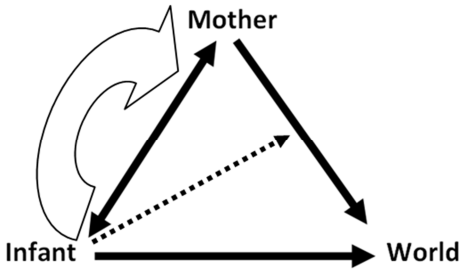

Figure 10. Primary and secondary intersubjectivity (Hobson 2004, p. 272)

In Hobson’s model, the axis between mother and infant, represented by a two-way arrow, was described as primary intersubjectivity. Alongside that, both mother and infant

also independently viewed external objects in the world. The developmental leap to secondary intersubjectivity occurred on these axes when the infant sensed that the mother's mind was independently focused on the world (represented by the curved arrow). At this point the infant might factor in the mother's attitude to objects in the world (represented by the dotted arrow) and perceive those objects in relation to her mind as well as their own. Isserow linked the process of looking together in art therapy triangular relationship with the wider field of the psychology of social referencing (Waldren and Kneeps, 1996).

To summarise: Art therapists have identified that the triangular relationship may be an unique feature of art therapy but no studies had resulted in attempts to operationalise the concepts in terms of descriptions of practice. Isserow's contribution to the triangular relationship was to connect the study of an innate human impulse to look together as a means of sharing mental content with a mechanism of change in art therapy. Isserow (2008; 2011) suggested that a greater understanding of what an art therapist actually does in this relationship, linked to emerging theory from attachment theory could increase the effectiveness of art therapy.

Given its defining presence within art therapy it would be useful at this point to explore whether the literature might reveal how art therapists had operationalised the concept of the triangular relationship for practice implicitly in their practice. I explored this by reading the literature with a specific focus on whether it offered any kind of practice description of that type. Given the subject of the present study concerns groups, I limited this phase of the literature review to examining how art therapists may have incorporated the triangular relationship into their group work.

Triangular relationship in art therapy groups. In their review of group-based art therapy literature, Skaife and Huet (1998) noted the dearth of literature compared to high

prevalence of groups as a means of delivering art therapy in clinical practice. They suggested this may be because key concepts, including the triangular relationship, were harder to describe in the group approach because it involved the complexity of additional layers of both person-to-person interaction and multiple artworks.

Waller (1993) observed that art therapists followed a pattern common to verbal therapies in being slow to recognise the value of groups. Waller suggested the history of the art therapy group had its origins in art therapy studios. Figure 11 shows the configuration of an art therapy studio at Netherne Hospital in the 1950s where the art therapist would work with mental health service users like a tutor, moving individually from one to the next to talk about their art. Note that service users do not face each other, as the primary communication was with the art therapist and with the artwork but less so with each other.

Figure 11. Art therapy studio in 1950s (from Waller, 1993, p. 10)

Waller described how pioneering art therapists, many of whom were employed as art instructors, became more involved with what people said about their artwork. She described this group approach as a compromised practice suggesting the art therapist found themselves having "(...) whispered conversations in a corner of a room to the exclusion of other patients." (Waller, 1993, p. 8). Waller contended that group art therapy

evolved out of recognition that this was both an unsustainable practice and because it did not engage the usefulness of how service users influenced each other in their imagery or spoke to each other about the content of their artworks.

In the USA, Wadeson (1980) suggested a different approach to group art therapy where each group member spoke to the whole group about their artwork in turn. She suggested this approach to group work might offer advantages over verbal groups because it facilitated a greater equality of focus, particularly for withdrawn service users who might not always speak in verbal groups. The first UK reference to group art therapy in the *International Journal of Art Therapy* was in 1983. The art therapist Gerry McNeilly (1983) had recently trained in group analysis and proposed a model of art therapy groups based on the work of the group analysis founder Foulkes (1964). The group analytic art therapy model described the therapist's approach as differentiating little from verbal groups but greatly from Wadeson's (1980) conceptions of groups. The basic tenets were:

1. "No set direction or topic
2. The aim is self (group) exploration, group treating itself
3. Figure/ground and here and now understandings
4. The major part played in understanding the group inclusive of the conductor" (McNeilly, 1989, p. 156)

The focus was on meta-group process and McNeilly simply included art-making and art-viewing as he would any other phenomena within a group:

> "As with the gestalt principle the art production shifts to fore and background. There is less pressure in this type of art therapy to justify the triangular arrangement of patient, art therapist and artefact and to explain the imagery and find meaning." (McNeilly, 1987, p. 157).

Whilst the emphasis was on an egalitarian approach to understanding the group, the art therapist somewhat paradoxically took a hierarchical stance of being the interpreter of what was said in the group or about images. The art therapist would approach each image with a stance of answering the question: “Is this conscious or unconscious?” (McNeilly, 1989, p. 161). McNeilly recommended art therapists aim to provide an optimal level of frustration for service users; no direction was given in terms of time for art-making including whether services users needed to do make art at all. Groups would often begin and involve long silences which were endorsed as part of the processes of revealing unconscious material: “When a group sits in silence at its beginning, it is on the threshold of chaos: the unconscious." (McNeilly, 1984, p. 208). McNeilly described sometimes not talking at all in a session and sometimes not even looking at some of the imagery produced (McNeilly, 1987). Practitioners were cautioned against “chasing after individual images” (McNeilly, 1987, p. 10) and recommend focusing on the resonance between artworks in the group matrix.

The model was criticised by Thornton (1985) who suggested that McNeilly had merely subsumed art therapy into group analysis. He noted the slowness of that verbal approach and how many service users tended to drop out of it in the reality of practice in public sector settings. McNeilly later modified his position, suggesting the approach would be unlikely to be suitable for those with “severe psychopathology” though this condition was not specified further. (McNeilly, 1987, p. 163). The group analytic art therapy model was defended as an alternative to Wadeson’s (1980) turn taking conceptualisation of groups by Skaife (1990). Skaife suggested it had superiority in terms of equalising participation because it facilitated growth through self-determination.

Studio-based art therapy focused more on art production than group interaction (though not prohibitively so). It was argued the studio model facilitated less verbally able

or more disturbed services users to find their way into human relations through a gentle experience of being in the room with others. This conception of the triangular relationship gave the artwork more prominence, particularly at the start of therapy. It was suggested that insistence that everyone should meet together explicitly for talking from the start in the group analytic model risked alienating vulnerable service users (Deco, 1998; Hyland-Moon, 2002).

Even though the group analytic model had received criticism, and represented one approach amongst many, it became highly influential. It was adopted as the model used to train art therapists, from their first introduction to the profession through to qualification (Dudley, Gilroy & Skaife, 1998; Gilroy, 1995; Waller, 1993). Leading tutors described a group analytic teaching approach whereby all learning was located in "group process." A description of this practice included tutors not answering student questions because they considered doing so was "a collusion with their anxiety" (Dudley, Gilroy and Skaife, 1998, p 190). Tutors formulated the resulting anger from students as an indication of the maturational process in the group from dependency on its leader to self determination (Gilroy, 1995). This rigid group analytic approach began to be modified only by the end of the 1990s where it was accepted that some didactic teaching was needed in experiential groups. At this point Dudley, Gilroy and Skaife (1995) undertook a pre and post evaluation of this teaching approach in an introductory session for people considering future training in art therapy. A "large number" of attendees felt they had learned a lot about themselves and art therapy group process, but a "large number" of them also felt they did not learn about clinical approaches to art therapy. These results reflected a similar study by Gilroy (1995) who undertook a questionnaire-based survey during professional art therapist training. Questionnaires were administered at the start, mid and end point of an experiential group lasting one academic year. The mode of analysis was not described

but the author claimed trainees predominantly cited personal learning as having occurred more than professional learning in terms of clinical technique.

In contrast to art therapy trainers, art therapist practitioners continued to develop highly structured art therapy group approaches where the therapist gave directives about what to draw and offered structure in by asking each service user to describe their image to the group in turn (Cambell, 1993; Lieberman, 1986). The relationship between structured groups and analytic groups in art therapy became characterised as a debate around directive and non-directive approaches (McNeilly, 1987). This debate technically referred to the setting of themes for art making, but later appeared to be inaccurately conflated with how active the therapist became (Skaife & Huet, 1998). Greenwood and Layton (1987) contributed to this debate by suggesting an approach which did not conform to the polarisation of either directive or non-directive. The authors described an outpatient art therapy group for people who experienced psychosis. They eschewed the idea of the therapist as an expert dispensing insight into unconscious processes and described a concept of side-by-side therapy where: “Showing the work and talking about the pictures together provides additional opportunities for the development of the self in relation to others and sharing and modifying anxieties.” (p. 14). Many of the descriptions offered by Greenwood & Layton were echoed in the description of a twice weekly art therapy group she had run as part of a therapeutic community for severely depressed adults by Nowell-Hall (1987). A strength of this paper was that it represented one of the earliest attempts to include service user experience of art therapy groups in its evaluation. This involved interviewing an unspecified number of service users using their artworks to prompt memory some seven to ten years post intervention. The responses were grouped into themes. She found that many service users were deeply fearful of all the groups the programme offered, but seemed to particularly value art therapy at the beginning of their

treatment. This appeared to have been because art therapy enabled group interaction through a number of specific mechanisms: it gave participants something definitive to talk about; allowed them to get to know one another through an activity; used their hands and bodies which alleviated anxiety; and involved incidental activity around art making which helped interaction (such as asking another group member if they could borrow a pencil during art-making) which helped service users to feel more comfortable with people.

Springham (1992; 1998) described structuring the discussion part of an art therapy group for people who had misused substances in a short term programme. Springham noted that groups aimed at specific conditions and within specific treatment contexts required adaptation from group analytic approaches. The substance misuse groups brought together service users who were all at a very early stage in their recovery and specifically worked towards motivating them to continue treatment. Springham used Yalom's (1970) formulation for an art therapy group structure where the art therapist focused on the interactions in the here and now of the therapy session and asked the group to frequently stop to reflect back together on what they say about their images in relation to that here and now. It was recounted that previous attempts to use a group analytic approach, with unstructured discussion had not worked in that setting, resulting in arguments and disengagement. Springham collected service user responses from questionnaires in order to evaluate their first response to the intervention (Springham, 1994). Fourteen service users were sampled before and after their first session of art therapy. Their predominant experience was of most being surprised at how quickly they were able to use an intervention they had anticipated having a negative response to.

Waller (1993) devised a model of group interactive art therapy which she claimed bridged group analytic art therapy and structured art therapy group styles (Waller, 2004). Once again, drawing on group analytic principles she put service user self-determination

as a central therapeutic agent: “Each group member is expected to take responsibility for his or her own participation in the learning of the group." (Waller, 1993, p. 17). The art therapist did not lead but interpreted the service user actions in the here and now of the group setting as transference re-enactments. Waller suggested here and now exchanges could be transformed into communication of the unconscious if linked to the meaning of the images. She suggested participants found their own meaning to their images from talking to each other and not to the art therapist, who did not offer suggestions but solely focused on group process. Waller only suggested the model may not be suitable for service users with more intractable difficulties. However, she proposed and used this model for the MATISSE study into schizophrenia.

Skaife and Huet’s (1998) book dedicated to art therapy groups did not promote one single model of art therapy, but aimed to show how art therapists adapted their practice to suit specific clinical populations and settings. Skaife and Huet expanded on how much action occurred within an art therapy group even beyond the combination of art making and verbal interactions: “We identify a central problem and that it is that *there is too much material*. In our groups we attempt to work with all of it." (p. 20). They recommend the art therapist should prioritise particular artworks which might symbolise the group process over other events in the group described as “the group image” (p. 21). In this sense, the artwork would be used as a means of bringing the group together in the triangular relationship.

Summary of art therapy triangular relationship as a concept and a description of practice. I reviewed the group-based literature to understand the extent to which art therapists had attempted to operationalise the triangular relationship. Art therapy practice might be described as having evolved pragmatically; building on pre-existing art projects in the hospital system and not through the application of psychological principles or

theory. Art therapy theory, as represented by the literature appears to have been written by a few prominent individuals, often linked to training courses. Their approach was predominantly to apply theory retrospectively to practice drawn from the verbal psychoanalytic disciplines they had recently trained in. Theory usually described the intention but not the action, of the therapist. This appeared to replicate many practice description problems faced by psychoanalysis itself, in that: “Clinical technique is not logically entailed in psychoanalytic theory." (Fonagy, 2006, p. 76).

The original concept of the triangular relationship emerged to try to describe a process that simultaneously accounts for the presence of persons and artwork in therapy. A limitation of the term is that it could refer to *all* interactions as soon as a service user, an art therapist and an artwork become present: In other words the term could simply mean all of art therapy including art making, art viewing or even washing up paint pallets. Art therapy group therapists debated how the triangular relationship was restored either through turn taking (Wadeson, 1980; Lieberman, 1986; Springham, 1992) or through group as whole interpretation (McNeilly, 1990; Skaife 1990; Waller, 1993).

Many models justified the lack of description about specific clinical conditions by privileging the philosophical and ethical definitions of their approach over specific actions. It was difficult to envisage how their practice might be replicated by other therapists solely by reported intentions. Therapist intentions predominantly sought to free service users from the medical model and empower them as individuals (Skaife, 1990; Waller 1993). Paradoxically, that egalitarian intention at points involved a model of the art therapist as an expert who simply *knows* the unconscious of their service user. This expert model had an impact on the development of evidence based practice: “The art therapist is often an expert in her or his area of work but undervalues that expertise because of the effects of the dominant scientific culture." (Schaverien, 1995, p. 25). It was also possible

that there was a correlation between the refusal of tutors to answer student questions in training groups (Gilroy, Skaife & Dudley, 1995) and the difficulties art therapists had in describing practice in MATISSE (Patterson et al., 2011).

Summary of Chapter Two

The three questions applied to the literature were:

1. What is the relationship between description of clinical practice and effectiveness in psychological therapy?
2. How has art therapy been defined?
3. How do art therapists describe their practice in the triangular relationship?

Preparation for conducting successful controlled research (e.g. RCTs) required that practice be defined and this often took the form of a manual. Practice description had been very limited in art therapy studies. The literature review revealed that art therapy had emerged as a practice, rather than a research orientated profession, with a long tradition in a wide range of public sector settings. This has resulted in a greater definition of the practitioner than the practice. Art therapists described their approached as psychoanalytic, placing high emphasis on the intention, rather than action of the art therapist. Therefore a definition of art therapy could only be summarised as the work an art therapist did. The triangular relationship was claimed as a uniquely defining feature of art therapy. However, the triangular relationship often only described the presence of artwork, service user and therapist. It was hard to infer what the art therapist did from the descriptions provided in the studies reviewed. The impact this appeared to have had on art therapy effectiveness research appeared to be in the neglect of practice descriptions and manuals. The MATISSE trial might be described as the culmination of that approach.

The present study explicitly aimed to link the actions of the art therapist to the difficulties of those diagnosed, assessed or described as experiencing a borderline

personality disorder. I wished to explore how psychological therapists, including art therapists, had defined their approach to this condition. The next chapter focuses on the literature pertaining to this condition.

Chapter Three: Borderline Personality Disorder, Mentalization and Art Therapy

The aim of this chapter is to outline the current thinking about borderline personality disorder and psychological therapy treatment. Within the current range of psychological therapy treatments suitable for people with a diagnosis of borderline personality disorder, literature relating to mentalization-based treatment (MBT) was subject to particular scrutiny because it was the mode of art therapy treatment studied. This included the definition of the concept of mentalization, its origins in attachment theory and psychoanalysis, and its application to the treatment of borderline personality disorder. The chapter then explores how art therapists approached their work to those given a borderline personality disorder diagnosis. Given that mentalization was a relatively new concept, with the first citation in an art therapy paper only appearing in 2004, it was necessary to widen the range of art therapy and borderline personality disorder papers beyond those using the mentalization treatment approach. The aim of this was to examine how art therapists described their approach to art therapy with people with a diagnosis of borderline personality disorder.

Search strategy. The research questions that defined the search strategy were:

(1). How has the experience of people with a diagnosis of borderline personality disorder and been defined?

(2). How has mentalization-based therapy been defined?

(3). How have art therapists approached their work in relation to both people with a diagnosis of borderline personality disorder and mentalization?

The search terms, which were combined in various ways, included: “personality disorder”; “borderline personality disorder”; “cluster B”; “emotionally unstable personality disorder”; “mentalization”. These were then each combined with the terms: “Psychological therapy”; “psychotherapy”; “psychoanalysis”; “therapy”; “art therapy”;

"art psychotherapy"; "creative therapies" and "arts therapies". This yielded 369 results. Two of the papers were in foreign languages. One in German (Kasuistik, 2006) was translated by a colleague. The second Turkish paper by Eren, Özdemir, Öğünç, Saydam (2005) was not able to be translated by a Turkish speaking colleague because it appeared to be badly translated from another source. In addition, grey literature was taken from coursework handouts from three trainings from the Anna Freud Centre in London in 2008, 2010 and 2012, and from the Attachment and the Arts conferences in London with the British Association of Art Therapists in 2010 - 2014.

Borderline Personality Disorder: Definition and Treatment

The 2009 National Institute of Clinical Excellence (NICE) guidance on psychological therapy with people with a diagnosis of borderline personality disorder, defined using ICD 10 criteria, summarised the evidence for treatment. NICE stated that when providing psychological treatment for people with personality disorder, especially those with multiple co-morbidities and/or severe impairment, particular service characteristics should be in place. The key features of the guidance were that care workers and service users should share a clear understanding of the treatment approach with particular emphasis on managing transitions and breaks in therapy. Brief therapy should not be attempted with those with borderline personality disorder symptoms due to the attachment issues involved with therapy requiring some working through for people who have suffered attachment trauma.

It was not known how many people with a diagnosis of borderline personality disorder have used art therapy to help them. However in 2005, the Art Therapy Practice Research Network developed and conducted a survey which asked questions about the severity of difficulties the service users attending art therapy had at a specified one week point (Evans, 2007). The questions asked art therapists to rate all the individuals on their

case loads from one (no difficulties) to five (extreme difficulties) on the following dimensions: difficulties verbalising; physical health problems; socio-economic difficulties; risk to others; risk from others; risk to self; engaging in relationships; trauma; and end of life. Ninety-seven art therapists responded and the survey revealed their caseloads contained highly traumatised, socio-economically deprived groups, who presented a risk to themselves and had great difficulty verbalising their feelings. This survey indicated, even without data on that precise diagnosis, the problems that the term borderline personality disorder seeks to describe were prevalent in art therapists' caseloads.

NICE guidance noted in 2009 that whilst research was still in an early phase, specialised psychological treatments which appear to meet needs of the those diagnosed with borderline personality disorder, such as Cognitive Analytic Therapy (Ryle, 1995), Dialectical Behaviour Therapy (Linehan, 1995) or therapeutic community based treatments (Haigh, 2002) did so because they had a clear structure and addressed the interpersonal functioning particular to the condition. No art therapy studies met the criteria for these NICE guidelines and this presented a gap for art therapists.

Psychodynamic therapies, particularly those which aimed at insight by exploring unconscious content through interpretation, gained a more mixed appraisal. Bateman & Fonagy (2006) noted that without treatment, the natural course of difficulties defined by the borderline personality disorder diagnosis was approximately six years, meaning that individuals no longer met diagnostic criteria as per DSM III. This was attributed to non-clinical factors such as moving away from dysfunctional families, gaining employment, forming different relationships. By contrast, when offered psychodynamic therapy only 66 percent of those people meeting borderline personality disorder criteria reached the same definition of recovery over a 20 years year period from the 1960s to 1980s (Stone, 1990).

> "It seems to us that there is no way to avoid the conclusion that some psychosocial treatments practiced currently, and perhaps even more commonly in the past, have impeded the borderline's capacity to recover following the natural course of the disorder and advantageous changes in social circumstances." (Bateman & Fonagy, 2006, p. 96)

Likewise, Hummelen, Wilberg and Karterud (2007) interviewed 96 women who had been diagnosed with borderline personality disorder who had dropped out of group analytic treatment and reported that most found the interpersonal challenge and psychoanalytic basis of the therapist's comments were beyond their ability to understand.

Concerns about the fit between the treatment and the condition it aimed to treat, in this case the specific interpersonal difficulties, led to the modification of the psychodynamic approach for people with a diagnosis of borderline personality disorder in the form of MBT (Allen, Fonagy & Bateman, 2008). The lasting efficacy of MBT was demonstrated in an eight year follow-up of MBT by partial hospitalization versus treatment as usual (Bateman & Fonagy, 2008). The sample size was 41 service users, measured on a range of standardised tools, structured interviews from an independent psychologist and evaluation of care records. The MBT approach included "expressive therapies" named as either writing or art. None of the treatment as usual received MBT during any part of the follow up period. The results are summarised below (Table 1):

Table 1.

Outcome of eight MBT year follow up

Measure	MBT	Treatment as normal
Service use	2 years	3.5 years
Medication use	0.02 years	1.90 years
Global functioning above 60	45%	10%
Vocational status (number of years in employment)	3.2 years	1.2 years

At the end of the eight-year follow-up period only 13% of the MBT group met diagnostic criteria for borderline personality disorder. Conversely 87% of treatment as usual group remained diagnosable as borderline personality disorder, despite the latter having had far more input over the time period: “More striking than how well the mentalization-based treatment group did was how badly the treatment as usual group managed within services despite significant input.” (Bateman & Fonagy, 2008, p. 636).

Whilst previous studies into the efficacy of psychological treatment for people with a diagnosis of borderline personality disorder had shown promise in many areas, interpersonal functioning remained poor after treatment (Brazier et al., 2006). After the eight-year period MBT raised interpersonal functioning as measured on the Zanarini personality disorder scale for borderline psychopathology (Zanarini, 2003), particularly in improving areas of intense and unstable relationships and frantic efforts to avoid abandonment. The duration these outcomes remained were deemed by the authors to be encouraging because positive effects of treatment tend to diminish over time. Whilst the study was that it had well defined interventions with long-term follow up after randomisation, it involved relatively small numbers.

Similar results were found in an 18-month follow-up MBT study (Bateman & Fonagy, 2009). Here, service users (N = 134) consecutively referred to a specialist personality disorder treatment centre and meeting selection criteria were randomly

allocated to MBT or structured clinical management treatment (this being comparable to treatment as usual in the Bateman and Fonagy (2008) study above). Independent evaluators, blind to treatment allocation, conducted assessments every six months. Substantial improvements were observed in service users randomly assigned to MBT, showing a steeper decline of both self-reported and clinically significant problems such as suicide attempts and self-harm. A strength of these two major studies comparing MBT to treatment as normal was that they both involved people with a diagnosis of borderline personality disorder who presented high risk to themselves and the study was carried out in a naturalistic treatment setting. The MBT approach was clearly described and was compared with treatment as normal. A limitation was that both MBT studies were carried out by the main proponents of the treatment approach which may at some level create bias. Neither study was been replicated independently.

Given the dominance of psychodynamic practice in art therapy, the development of MBT as a treatment for people with a diagnosis of borderline personality disorder from that same theoretical background had many implications for art therapy. In order to explore this, it was necessary to examine the concepts involved in MBT theory.

Defining mentalization. The Oxford English Dictionary (2003) cited the first recorded use of the term “mentalize” in 1807 and currently gives it two senses: first “to construct or picture in the mind, to imagine, or to give a mental quality to” and second “to develop or cultivate mentally or to stimulate the mind of” (p. 220).

The understanding of mentalization as a clinical concept was developed through a strategy of synthesis, drawing on areas where separate fields of study overlap:

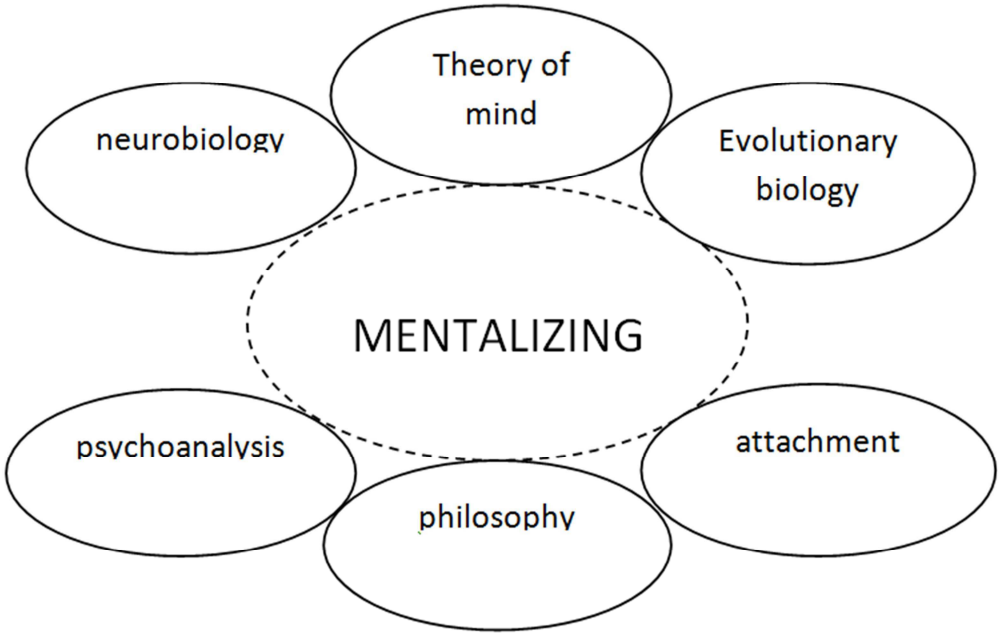

Figure 12. Links to other domains of knowledge (Allen & Fonagy, 2006, p. 25)

The use of the term mentalization within a psychological context had its roots in developmental psychology in relation to the investigation of young children's false beliefs about the world (Wellman, 1990; Perner & Lang, 2000). Morton and Frith (1995) used the term "mentalizing" because existing terminology failed to encapsulate the relational and affect regulative aspects of interpreting behaviour in mental states. Fonagy cited similar failures of existing taxonomy as justification for the term in relation to psychotherapeutic concepts:

> "(...) the term symbolization, which is over-burdened with meanings, particularly in psychoanalysis. It is certainly not possible to restrict it to the notion of the secondary representation of mental states. For the sake of brevity I would like to label the capacity to conceive of conscious and unconscious mental states in oneself and others as the capacity to mentalize." (Fonagy, 1991 p. 633).

Mentalization was posited as defining a crucial element of mental activity underlying all forms of psychotherapy, a common mechanism of change (Fonagy, Bateman & Bateman, 2011). Because the definition of mentalization was a refining of

existing basic concepts within a new framework of related fields of science it has been described as: “... the least novel therapeutic approach imaginable." (Allen & Fonagy, 2006, p. 24). Yet even within that framework, the term mentalization has been developed because it has been claimed that it offers a particular utility in identifying a specific mechanism. For this reason it has been defined in contrast to the fields it overlaps with (Table 2):

Table 2

Differentiating “Mentalizing” from overlapping terms (Allen, Fonagy & Bateman, 2006, p. 41)

Term	Distinctions
Mentalizing	Attending to mental states in self and others, and interpreting behaviour accordingly
Mindblindness	Antithesis of mentalizing: employed originally to characterise autism
Mindreading	Applies to others and focuses on cognition
Theory of mind	Focuses on cognitive development and provides a conceptual framework for mentalizing
Metacognition	Focuses primarily on cognition and belief
Reflective functioning	Operationalises the general level of mentalizing
Mindfulness	Focuses on the present and is not limited to mental states
Empathy	Focuses on others and emphasises emotional states
Emotional intelligence	Pertains to the mentalizing of emotion in self and others
Psychological mindedness	Characterizes the disposition to mentalize, broadly defined
Insight	Mental content that is the product of the mentalizing process

Theory of mind was itself a concept closely linked with the notion of empathy. The definition of empathy had developed in the last 20 years. Baron-Cohen (2005) later amended his theory of mind theory to move beyond solely focusing on cognitive elements to include emotion detector and empathy system as a feeling response to others. This extended his concept of empathy to more than just a cognitive understanding of why others behave in a certain way. In addition to empathy for other people MBT also emphasised empathy for the self.

Mentalization was been referred to as “mindfulness of mind” (Allen & Fonagy, 2006, p. 43), but the concepts do not completely match. Mindfulness was defined as “an enhanced attention to and awareness of current experiences or present reality characterised by especially open and receptive attention” (Brown & Ryan, 2003, p. 882). Mindfulness could be applied widely with mindfully directed practices focusing variously on a flower, candle or breathing, whereas the focus of mentalization was more limited, with attention directed to mental states. Mindfulness was often centred on practice in quiet surroundings, whereas mentalization was encouraged in the midst of intense emotional states. The quality of awareness had been differentiated between the two concepts. In reviewing the neurological basis to both practice Allen (2013) described how mentalization involved the medial prefrontal cortex with emphasised processing in the language centers of the *left* hemisphere. By contrast mindfulness tended to deactivate the medial prefrontal cortex and increase the *right* lateral cortical network. Allen therefore described mindfulness as bare non-conceptual *attention* and mentalization as narrative based autobiographically determined *reflection*. The clinical MBT approach named stop and rewind (described below) encouraged a toggling between mindfulness (stop) and mentalization (rewind). Other differences were that mentalization was not solely concerned with the present moment but included a focus on both past and future mental states.

***Measuring mentalizing*.** Mentalization was currently measured by the reflective functioning (RF) scale (Steele & Steele, 2008). RF scale was used to code the reflective functioning of respondents undertaking the Adult Attachment Interview, which rated the attachment styles of adults drawn from interviews wherein they retrospectively described their childhoods (George, Kaplan & Main, 1985). Coding of “reflective functioning” was a way to operationalise the concept of mentalization and involved looking at thinking as revealed in interview narratives about important emotional attachment relationships, to see

how far the person drew on an internal psychological model of motivation about what happened in close relationships. The RF scale was used to demonstrate statistically different outcomes in reflective functioning between people with a diagnosis of borderline personality disorder and people without a diagnosis of borderline personality disorder (Fonagy et al., 1991). A criticism of the RF scale by its designers was that its use with the adult attachment interview was too cumbersome to use within treatment settings. Even though the RFS has since been modified in the form of a manual, the manualised scales had not been used in studies to replicate the above comparison between people with a diagnosis of borderline personality disorder and people without a diagnosis of borderline personality disorder (Choi-Kain & Gunderson, 2008). Given this limitation for clinicians, Fonagy and Allen (2006) developed the levels of mental elaboration scales (Table 3) as a guide to assess mentalization within treatment settings. This remained purely an observational heuristic which had reduced value when taken outside of its attachment theory context.

Table 3

Levels of mental elaboration (Allen & Fonagy, 2006, p. 111)

Negative RF	Active, hostile resistance to the mentalizing stance; derogation of reflection; bizarre or frankly paranoid attributes – all in the context of a total absence of reflection.
Lacking in RF	Reflection is totally, or almost totally, absent; banal and simplistic mentalizing; extreme concreteness; clearly inaccurate attributions indicative of failure to reflect
Questionable or low RF	Rudimentary consideration of mental states; relatively superficial and impersonal; generally, references to mental explicated; alternatively, over-analytical, uninterested insights not linked to the individual's experience.
Ordinary RF	Common in non-clinical populations; a number of instances of reflection indicating that the individual maintains coherent models of the mind for the self and attachment figures; ability to make sense of experience in terms of thoughts and feelings; somewhat lacking in complexity or subtlety; indications of limited reflection regarding other relationships
Marked RF	Consistently maintained reflectiveness evidencing the effort to tease out mental states underlying behaviour; detailed understanding of thoughts and feelings of protagonists; originality in thinking about mental states associated with actions; ability to maintain a developmental and intergenerational perspective
Exceptional RF	Rare cases of exceptional sophistication, coupled with consistent maintenance of a reflective stance throughout; integrating several instances of reflectiveness into unified and fresh perspectives, full and spontaneous reflection with respect to a range of relationships across the speaker's life history.

The concept of mentalizing had been developed by cross referencing a range of evidence, but attachment theory has been one of its most substantial building blocks. Observation was a key research approach from the start of attachment theory (Bowlby, 1950) and that has greatly affected how the MBT approach has been operationalised. With this in mind it would be useful to outline those links between attachment and mentalization for people with a diagnosis of borderline personality disorder.

Attachment theory and people with a diagnosis borderline personality disorder: implications for mentalization-based treatment. Within the domains of knowledge MBT drew on, the links between psychoanalysis and attachment theory produced particularly novel and sometimes controversial insights for practice. In

reviewing literature on social biofeedback theory of affect-mirroring Fonagy et al., (2004), found evidence for seeing the infant as an observer of himself through other people. This is particularly so in the experience of emotions:

> "We propose that the dispositional content of emotions is learned first by observing the affect-expressive displays of others and associating them with the situations and behavioural outcomes that accompany these emotional expressions." (p. 152)

Levy's (2005) expert review of the attachment theory evidence indicated that while the relationship between people with a diagnosis of borderline personality disorder and a specific attachment category was not yet obvious, there was little doubt that borderline personality disorder was strongly associated with early attachment insecurity. Levy suggested attachment insecurity was a relatively stable characteristic of people with a diagnosis of borderline personality disorder, particularly in conjunction with subsequent negative life events. Eighty four percent of people with a diagnosis of borderline personality disorder respectively reported experience of neglect and emotional abuse from both parents before the age of 18 years with emotional denial by the caretakers of their experience (Zanarini, 2000; Linehan, 1995). The quality of children's primary attachment relationship has been shown by a number of studies to predict mentalizing ability in terms of emotional, rather than cognitive understanding. There was suggestive evidence that disorganised attachments led to problems in affect regulation, attention and self-control (Lyons-Ruth, Yellin, Melnick & Atwood, 2005; Sroufe, Egeland, Carlson & Collins, 2005). It was proposed that characteristic problems experienced by people with a diagnosis of borderline personality disorder, such as affect regulation and sense of self, are mediated through a failure to develop robust mentalizing capacity.

Summarising a large body of neuroscience research, Fonagy and Luyten (2009) pointed out that adults with a diagnosis of borderline personality disorder appear to have a lower threshold for the activation of the fight or flight system and an associated readiness to deactivate mentalizing. A great deal of the neurobiological research with people with a diagnosis of borderline personality disorder focused on the role of the amygdale as a neurochemical switch (Arnsten, 1998) which activated a dual process of heightening a bottom up limbic response and a reduced top down cortex control. In people with a diagnosis of borderline personality disorder this was more readily activated in social situations compared to those people without a diagnosis of borderline personality disorder. In a study where six people with a diagnosis of borderline personality disorder were shown neutral faces there was increased activity in the amygdale compared with the control group (Herpetz et al., 2001). The lower threshold for the neurochemical switches to be activated in social situations was central in understanding how mentalizing was compromised for people with a diagnosis of borderline personality disorder.

The relationship between affect regulation, neurobiology and attachment theory was made through an understanding of how the brain required intense levels of emotional responding to function: “The brain’s first and most powerful approach to affect regulation is via social proximity and interaction.” (Coan, 2008, p. 255). It was proposed that those people with a diagnosis of borderline personality disorder were unable to form the depth of attachments through intimate relationships that enabled this form of interpersonal affect regulation to take place effectively (Fonagy et al., 2004)

MBT was directly informed by attachment theory in what has been termed contingent and marked mirroring sequences (Allen & Fonagy, 2006). Mirroring was noted within psychoanalysis most prominently by Winnicott who proposed it was as a mechanism at work in psychotherapy (Winnicott, 1971). MBT shared a common concern

with Winnicottian principles to empathise with the service users experience *first*, before attempting to offer therapist viewpoints. However, MBT did not share the more traditional psychoanalytic passive, blank screen, stance that Winnicott appeared to adopt in his practice. The concept of mirroring in attachment theory assumed the imitation of behaviour provided a bridge that allowed the internal mental state of another to "cross-over" to and become the subject's own experienced mental state (Meltzoff & Gopnic, 1993). The relationship of self-other representations was core to understanding the concept of mirroring.

Mirroring was observed as occurring within a specific sequence where *contingent* mirroring was followed by *marked* mirroring. The former referred to the infant's requirement for responses from the primary caregiver that matches the movements or sounds they had instigated. The latter referred to a playful change in the later part of the primary caregiver's response *after* she had established a connection through contingent mirroring. This change 'marked' her response, and by implication herself as an entity, as differentiated from the infant. The sequence was important. Studies with infants using the still face procedure (Tronick et al., 1975) or delayed feedback techniques (Murray & Trevarthen, 1985) suggested that "(...) young infants were sensitive to the contingency structure of face to face interaction by three months and were actively searching to re-establish such a pattern of communication when abruptly deprived of it." (Fonagy et al., 2004 p. 156). Verisimilitude was the key feature of contingent mirroring. Lack of available or ineffective contingent 'mirrors' from the primary caregiver could result in infant disturbance. Intrusive or negative affect expressions from primary caregivers to infants instigated demonstrable detachment from contingency seeking in infants (Bettes, 1988; Tronick, 1989). Once contingent mirroring created empathic engagement, primary caregivers tended to add modifications to their mirroring. Playful singing by primary

caregivers building on top of accurate, contingent, mirrored infant utterances was observably soothing (Fonagy, et al., 2004).

Baron-Cohen (2003) suggested marked mirroring as central to the development of second order representations. Second order representations allowed experiences to be thought about by the subject not as concrete reality, but as “as-if” representations of experience. Second order representation was described by Hobson (2004) as an outcome of primary intersubjectivity (Trevarthen, 1993). Second order representations were viewed as a feature lacking in autism, a condition that shared similarities of difficult interpersonal functioning experienced by those people with a diagnosis of borderline personality disorder but which had a different aetiology. The detection of contingents was similarly impaired and the ability to think non-concretely was restricted (Baron Cohen, 2003). Likewise the general ability to play was inhibited by anxiety. Baron Cohen suggested that this was because if only first order representations were available then all mental content would be potentially confused as being real and must not be altered. The process of generating second order representations of experience through human interaction was one of mentalization (Fonagy et al., 2004).

> “Exploring the meaning of others' actions, in turn, is crucially linked with the child's ability to label and find meaningful his own psychic experiences, an ability that we suggest underlie affect regulation, impulse control, self-monitoring, and the experience of self-agency. Service users with certain personality disorders in childhood or adulthood cannot reliably access an accurate picture of their own mental experience, their representational world.” (Fonagy & Target, 1998, p. 92)

It was suggested that lack of second order representations could result in the transient psychotic states associated with people with a diagnosis of borderline personality disorder (Bateman & Fonagy, 2008). Instability in representation of mental states for self

or other had an impact on the interpersonal functioning of people with a diagnosis of borderline personality disorder: “Treating friends like strangers and strangers like friends." (Holmes, 2009, p. 89). A number of authors describe problems with identity diffusion, differentiating self and other, as central to defining who should be categorised as experiencing borderline personality disorder (Gunderson, 2001; Kernberg, 1987; Morgan, Knight, Bagwash & Thompson, 2012). Deficits in generating stable self-other mental representation threatened catastrophic consequences for any kind of perceived abandonment: “A highly significant explanation for the difficult lives led by borderline patients is that they cannot represent absence but alternate between closeness and nothingness. In other words absence has no positive value but is entirely negative." (Gammelgaard, 2010, p. 95).

Difficulties with distinguishing self from other people with a diagnosis of borderline personality disorder were demonstrated in analogue studies using film clips (Arntz & Veen, 2001). In a study participants meeting diagnostic criteria for borderline personality disorder categories (N = 16) were compared with controls of participant meeting cluster C personality disorder criteria (N = 12) and non-personality disorder participants (N = 15) were shown six films, which aimed to show the personalities of those within the scenarios. All participants were coded by “affect-tone of ascribed qualities” and “complexity of evaluation” criteria aiming to assess the level of interpersonal theorising (or mentalization) participants demonstrated. Those people with a diagnosis of borderline personality disorder showed lower scores in all cases on both dimensions. The implication of this was that those people with a diagnosis of borderline personality disorder had fewer representational models to draw in to assess the motives or mental states of others, essentially meaning they find it harder to mentalize.

Studies by Bartels and Zeki (2000; 2004) suggested that when the attachment system was activated brain areas associated with social judgments and mentalization, particularly the prefrontal medial cortex, were inhibited (such as in clouded judgment when falling in love). The medial prefrontal cortex was originally thought to have evolved to allow homo-sapiens to use tools together, but current thinking suggests that it evolved because of the sheer complexity of human social relationships. Indeed, many neurobiologists believe that the human brain has adapted so many systems for the purpose of attachment so that the whole outer cortex may be considered as being formed by affiliation, for affiliation (Allen, 2013). Bateman and Fonagy (2006) suggested that under stress most people in the healthy population found the process mentalization might be inhibited at exactly the point it is needed most, but might generally rely on being able to talk to another person to help them regain mentalization. By contrast, those people with a diagnosis of borderline personality disorder were liable to a double jeopardy: increased susceptibility to stressful relationships accompanied by difficulties in utilising intimacy needed to down-regulate that stress. For example, Bartz et al., (2011) studied the effect of Oxytocin, the hormone closely correlated with driving human attachments, with people with and without a diagnosis of borderline personality disorder in co-ordination tasks. In a study with 27 participants N=14 of whom six met diagnostic criteria for borderline personality disorder and 13 who were not. Half of each category was blindly given exogenous nasal Oxytocin and the other half given placebo. Groups were then set the "assurance game task" (Kollock, 1998) which involved trusting another with a nominal sum of money in order to retrieve mutually beneficial returns on an investment. Those who received OXT from the non-borderline personality disorder category found it increased their cooperation whilst those from the borderline personality disorder category found it decreased their ability to cooperate. This indicated that:

> "Individuals with borderline personality disorder may show an altered response to exogenous Oxytocin because the effects of OXT on trust and pro-social behaviour may vary depending on the relationship representations and expectations people possess and/or altered Oxytocin system functioning in borderline personality disorder." (Bartz et al., 2004 p. 560).

The results of this small-scale study were tentative related to studies undertaken by Zak (2012) who demonstrated similar problems with Oxytocin where the individual had suffered neglect and trauma in childhood.

The MBT hypothesis proposed that because of extensive attachment neglect and trauma that many people with a diagnosis of borderline personality disorder suffered in early life, their ability to work collaboratively in a close relationship with the therapist could not be taken as a given. Problems of close interaction with attachment figures included the therapeutic relationship. Indeed, that which was so central to psychotherapy, the therapeutic relationship, was itself a primary barrier to treatment. Therefore any interpersonal approach aiming to treat people with a diagnosis of borderline personality disorder must take account of the difficulties within the therapeutic relationship or risk being ineffective or even harmful. An understanding of the particular way the attachment system worked for people with a diagnosis of borderline personality disorder was therefore central in designing MBT. MBT sought to address how such deficits could be mitigated in order to overcome the poor interpersonal functioning which so often damaged the therapeutic alliance between those people with a diagnosis of borderline personality disorder and mental health professionals. This approach is now described.

The mentalization-based treatment approach to people with a diagnosis borderline personality disorder: description of practice. The MBT model was predicated on a number of assumptions. That other people's minds were opaque and

required investigation. Very often people with a diagnosis of borderline personality disorder would leap to conclusions. These conclusions were held with certainty because they were not perceived as provisional mental hypotheses about reality, but as reality itself. This process became worse when in an intimate relationship which caused hyper-activation of the attachment system. The aim of MBT was to deliberately prioritise mentalizing over all other concerns (such as insight, exploration of the past, etc.) within the inherent stress of the therapeutic encounter. The MBT practice model stated the therapist's first task was to monitor the service user's level of mentalizing. Bateman and Fonagy (2006) identified three types of pre-mentalistic ways of representing subjectivity that people with a diagnosis of borderline personality disorder were likely to present with when they are struggling to understand their own minds or the minds of others.

Psychic equivalence: in this frightening state the service user experienced the mind as reality. An example would be a "flashback" where internal reality has the same power as external reality. Alternative perspectives were intolerable because there was no 'as if' function. This state was the apparent "borderline" observed between psychosis and neurosis that the term borderline personality disorder originally referred to.

Pretend mode: Often accompanied by an experience of emptiness, it involved a dissociation of feelings so that words became meaningless. It could be very confusing in therapy as it appeared to mimic insight but created no affect regulation.

Teleological mode: The service user found it difficult to detect motive unless it was demonstrated in unambiguous terms. The term teleological referred to analogous reasoning i.e. the therapist only cared if they gave a hug.

To impact on these modes and to help the service user to mentalize, the therapist needed to utilise mirroring to reduce the distress or moderate the sense of emptiness the

service user was experiencing. Crucial to the MBT model was the sequence of contingent mirroring followed by marked mirroring. It was essential to find where the service user was, to understand their perspective (contingent) before moving on the offer alternatives (marked):

> "The patient has to find himself in the mind of the therapist and, equally, the therapist has to understand himself in the mind of the patient if the two together are to develop a mentalizing process. Both have to experience a mind changed by a mind." (Bateman & Fonagy, 2006, p. 93).

MBT had an active stance, where long silences or ambiguity were avoided. In the case of people with a diagnosis of borderline personality disorder attention was paid to not hyper-activating that system, such as by trying to offer soothing vocal tones which may be misread by the service user as seductive or patronising, or silences which may trigger feelings of abandonment for example. The MBT stance was characterised by:

- Curiosity and not knowing
- Patience in taking time to identify different perspectives
- Legitimising and accepting different perspectives
- Active questioning of the patient about their experience (what rather than why questions)
- Carefully abandoning the need to understand what makes no sense (saying explicitly something is unclear) (Allen & Fonagy, 2006, p. 45)

MBT demanded a high level of structure both in the way treatment was set up and the way it was delivered. The concordant therapy model it drew on tended to be used more in the US where as many people with a diagnosis of borderline personality disorder in the UK had predominantly been treated within a psycho-dynamically based form of group analysis (Foulkes, 1964; Foulkes & Parkin, 1957) or residential therapeutic community

models which themselves shared many philosophical approaches with group analytic principles (Haigh, 2002). MBT group work was differentiated from the group analytic approach in the following (Table 4):

Table 4

Comparison of dynamic and mentalizing groups (Karterud & Bateman, 2012, p. 86).

Dynamic group therapist	Mentalizing group therapist
Passive> active	Active>passive
Negotiates rules, regulations, norms of behaviour	States rules, regulations, norms of behaviour
Observer>participant	Participant>observer
Group> individual-orientated focus	Individual>group focus
Group-as-a-whole interventions-some	Group-as-a-whole interventions-rare
Stop, slow, or "rewind" the group – rare	Stop, slow, or "rewind" the group-common
Leave it to the group	Intervene
Change through finding self in the group	Change through stimulating mentalizing in complex interpersonal context.

To summarise, the MBT model was condition specific, but not linked to any particular school of therapy. It drew upon various domains of knowledge to understand the impairment those people with a diagnosis of borderline personality disorder face that directly impact on therapy. The MBT stance was designed to address those barriers and was characterised by encouraging curiosity and questioning at every opportunity. The therapist prioritised a concern with the process of thought over the content of thoughts. They aimed to help the service user to generate multiple perspectives, to free themselves from being stuck in the 'reality' of one view, to experience an array of mental states and to recognise them as such. Attention was paid to mentalizing and its relationship to the arousal (both hypo and hyper) of the attachment system.

Art therapy and mentalization. The literature review in chapter two of the present study revealed that group analysis had been the primary influence on art therapy groups in the UK in both practice (McNeilly, 2004; Waller, 1993; Skaife, 1990; Sarra,

1998) and training (Gilroy, 1995). Given that table 4 had sought to differentiate group analytic and MBT approaches to groups, this had a limiting influence of how art therapy literature could be used to fill the gaps in knowledge about mentalizing in art therapy groups. However, art-making was used in mentalization-based treatment included in RCTs (Bateman & Fonagy, 2008; 2009), though it was not referred to as art therapy. Its objective was described thus:

> "The aim of expressive therapies in the (MBT) day-hospital programme is to offer an alternative way of promoting mentalization. The use of art, writing, or other expressive therapies allows the internal to be expressed externally so that it can be verbalized at a distance through an alternative medium and from a different perspective. Experience and feeling is placed outside of the mind and into the world to facilitate explicit mentalizing. Under these circumstances mentalizing becomes conscious, verbal, deliberate, and reflective." (Bateman & Fonagy, 2004, p. 172)

The first use of the term mentalization in art therapy was in Norway by Johns and Karterud (2004) and it was in relation to people with a diagnosis of borderline personality disorder. This paper explored the processes of mentalizing as a way of understanding artworks as externalisations of inner thoughts and feelings, described as self-objects. Banks (2012) used the mentalization to describe a treatment approach within a forensic mental health setting, and emphasised the focus on process of thinking rather than content in art therapy. These studies described very little about the mechanisms in art therapy, or actions taken by the art therapist that might bring about those improvements in mentalization. The term was not explored further. The only other study not related to people with a diagnosis of borderline personality disorder was undertaken by Michaelides (2012) who explored art therapy and mentalization via the experience of a psychotic

individual in a group setting. Her focus was on the negative reflective functioning of an individual attending an art therapy group. The strength of her exploration sought to address the specific mechanisms involved in art therapy groups, which increased the service users mentalizing capacity. Noting that verbal MBT placed high emphasis on explicit mentalizing, the attempt to consciously and deliberately focus on mentalizing dimensions, she described the case of a service user who was unable to do so. He could neither discuss his image or his feelings when prompted by the art therapist or other group members. In asking the group to discuss his image in his presence she noted that he then responded by raising his head or saying "Yeah" at certain points made by others, which was in marked contrast to his almost complete lack of any interest in the direct verbal interpersonal exchanges in the group. Michaelides theorised this event in terms of Isserow's (2008) model of joint attention in art therapy, noting that his response required an increased self-other awareness and ability to hold two things simultaneously in mind. This would appear to correlate strongly to the joint attention processes in groups described by Springham, Thorne and Brooker (2014) where there was a powerful inter-subjective experience in having others describe one's own artwork. Michaelides noted the interest demonstrated in his image by others stimulated and increase in his own curiosity of his mental content as an increase in reflective functioning rated by the art therapist.

Criticisms of mentalization-based treatment. Group analysts criticised concordant therapy and particularly MBT on a number of counts. Firstly, group analysis viewed individual work alongside the group as a devaluation of the group process. Secondly, that the focus on the individual's experience of the group merely constituted individual therapy in a group and did not utilise the potential of group process fully. These criticisms, and the highly active stance of the MBT group therapist, were criticised as fostering dependency in service users (Bhurruth, 2004). Addressing the criticism that the MBT group approach

fosters dependency Karterud (a group analyst) and Bateman suggested that it was “Not activity or passivity but the therapist signalling explicitly or implicitly a sense that the therapist has some sort of privileged access to the unconscious of the individual.” (Karterud & Bateman, 2012, p. 100). They countered that the group analytic approach was based on an idealization of the ability of groups to self-manage all conditions they aimed to treat. Holmes (2009) identified criticisms of mentalization from two sides of the issue of empiricism in psychological therapy. Psychoanalytic circles and the Francophone schools in particular objected to both the linking of psychoanalytic principles with other domains of science, as per the Anglo-Saxon model of empiricism (Holmes, 2009). Psychoanalytic schools most often suggested that what was being described by the term mentalization was already covered by psychoanalytic concepts and offered nothing new (Holmes, 2006). On the other side empiricists suggested that validity of mentalization as a descriptor within psychological therapy has therefore been questioned (Choi-Kain & Gunderson, 2008). For example, whilst comparisons had been made between reflective functioning in mentalization and overlapping conceptual cousins of mindfulness, meta-cognitions and empathy, these had not been empirically examined to any great depth. Fonagy had admitted that was likely due the cumbersomeness of the available measures. It was suggested that without that level definition, whilst mentalization might appear to be a useful heuristic, it may be too broad to be operationalised as a marker for specific form of psychotherapy for people with a diagnosis of borderline personality disorder (Choi-Kain & Gunderson, 2008).

To summarise, whilst the number of people diagnosed with borderline personality disorder was high, the track-record of effectiveness in treatment for people with a diagnosis of borderline personality disorder was poor. Many of the treatments applied to people with a diagnosis of borderline personality disorder, such as group analysis, had

roots in psychoanalysis. The revision of the concepts that led to the term mentalization was translated into a revision of clinical practice pioneered at the Halliwick unit. The research evidence indicates that MBT may have some superiority over other treatments for people with a diagnosis of borderline personality disorder in addressing the interpersonal functioning difficulties which are so central to causing distress for this group of people.

At this point it would be useful to examine how these principles may operate, or differ in the art therapy approach that has been applied to people with a diagnosis of borderline personality disorder. A number of art therapists had written about mentalization beyond for treatment people with a diagnosis of borderline personality disorder and their insights were pertinent to the present study. Equally people with a diagnosis of have used art therapy services for some time. Art therapists had written about their experience of offering treatment specific to the condition, yet very little of this was framed in the mentalization model. This was likely due in part to the newness of the concept. Given the concept of mentalization was a common mechanism of change, their work was included in the present study because it was possible that they might describe identifiable mechanisms which related closely to mentalization but used different terms.

Art Therapy and People Diagnosed with Borderline Personality Disorder

Gilroy (2006) noted that although many art therapy studies explored issues of the personality disorder underlying other conditions such as addictions or eating disorder or in settings such as forensic mental health, few referred directly to the term as a diagnostic category. Franks and Whitaker (2007) questioned whether art therapists were comfortable working with diagnostic categories generally and personality disorder perhaps more than others. There was a very notable absence of literature on art therapy with people with a diagnosis of borderline personality disorder from the US literature. It was possible that the

system of managed care, with insurance funded treatments has disadvantaged people with a diagnosis of borderline personality disorder receiving art therapy.

The earliest paper was Silverman (1991) who offered a therapist-reported case study method. She suggested many diagnosed with borderline personality disorder were enthusiastic about art therapy. She noted the condition involved a difficulty in thinking as an abstract mental process and connected the process of making concrete representations of mental states and processes in art to this as a mechanism of change. She described art therapy as an opportunity to “think with things” (p. 83). Some therapist actions were described in the service of this aim, such as starting the service users off on their art making when they were terrified by the blank page as a representation of non-thinking. This involved either drawing a squiggle or a circle which the service user then filled in. In stating that “Because (the artwork) became a shared experience between patient and therapist, the illustration of the pain brought a sense of relief" (p. 92), it can reasonably be inferred that the therapist's attention was important in that process of "thinking with things." However, the absence of any description of how the art therapist acted to facilitate that sharing of experience gives an impression of them merely observing the service user represent borderline personality disorder processes in their artwork. This passive stance seems unlikely as so much of Silverman's descriptions are of interactive stance. The lack of description about how shared experience is generated is therefore a limitation of this paper.

Greenwood (2000) used a therapist-reported case study to describe art therapy with service users described as “borderline”. However, she then consistently referred to their narcissistic traits, particularly around an inability to form trusting relationships due to wishing to annihilate the therapist. This mixed description of the condition to some degree limited the contribution this study can make to understanding therapist action in to the

borderline personality disorder. In contrast to Silverman, she suggests unthinking states occurred not only prior to art-making but could actually be exacerbated by art-making itself. Her case study described a service user increasing in anxiety as she made art because: “Her artwork gave visual evidence of her badness and to draw was to risk her expression coming to life." (p. 17). Greenwood therefore disputed that art making was inherently safe in borderline personality disorder and suggested that it was the art therapist’s task to make it so. Greenwood claimed that the frightening content of the images was primarily reduced through the therapeutic relationship between therapist and service user. She described this processing as containing projective identification, a process where the service user projected un-integrated psychic material into the therapist who experienced it as sudden change in their own mental state. Greenwood’s viewed the therapeutic mechanism was in the therapist regaining their own mind under projective identification. By not acting out the projections the art therapist maintains a consistent and calm approach, which labels the projects as not real and so down regulates annihilation anxiety. It was not clear though to what degree this process occurred within the art therapist, as an internal process, or whether this was explicitly negotiated with the service user.

Lamont, Brunero & Sutton (2004) used a therapist reported case study, with expert review of images method to described the approach of an art therapy trainee to a service user diagnosed with borderline personality disorder as primarily engaging the service user with their image. A portfolio of 11 images were presented, but the interaction between service user and trainee art therapist was not described apart from a suggestion that at the end of the sessions that the service user should draw a calming image to help close the sessions. The study claimed the service user actively engaged with the art making, despite being emotionally dysregulated.

In 2004, Sigmund Karterud and his Scandinavian colleagues embarked on a series of evaluations of their personality disorder services. Karterud and Urnes (2004) asked what the optimal composition of day treatment programme should be for the short term day treatment programme for personality disorder using service user interviews; staff feedback; Review scientific evidence. All categories of personality disorder service users gave the art therapy group the highest significant rating. Moreover, the authors found the art group ratings correlated significantly ($P = 0.005$) with overall benefits of the treatment programmes they undertook using a range of measures. Exploring this further, Karterud and Pederson (2004) looked at the individual rating of individual components of treatment in relation to overall gains from the whole programme in a single site day hospital for personality disorder. The art therapy group was rated in order of preference by service users significantly higher than all other groups. Like Silverman, these studies suggest art therapy may be particularly valued by those diagnosed with borderline personality disorder. Service users rated the following factors as important therapeutic factors and these offer indications about therapeutic action:

- Non-competitive calmness of the group
- Being able to concentrate on their own mental images
- Being encouraged to find a personal expression of these images
- The response from fellow patients and the art therapist to their production
- Being witness to other's mental images
- Helping them to understand and reflect upon their own mind in comparison and contrast with the minds of others (Karterud & Urnes, 2004 p. 244).

The calm and non-competitive encouragement to explore mental states of self and other in art indicated in this list links with the sometimes hard won interpersonal tone of intervening described by Greenwood as a key action of the art therapist. When the authors

concluded that: “It seems like art group therapy favours development of mentalization and reflective functioning" (p. 246), they raised an interesting notion that art therapy may do so by operating sympathetically with the teleological level mentalizing for borderline personality disorder service users. Teleological functioning is a pre-mentalistic mode where the individual has some limited ability to infer mental states and intentions using analogous reasoning, but struggles if such intentions are not demonstrated through concrete manifestations (for example, my therapist only cares if they give me a hug). Art therapy as teleological sympathetic form of communication strongly echoes Silverman's notion of "thinking with things" because its points to concrete demonstrations of mind.

Johns & Karterud, 2004 used therapist self-refection to develop art therapy guidelines based around specific stages of the service users’ journey in art therapy, such as joining or leaving the group. This echoes Lamont et al (2004) in the art therapist giving special attention to transitions in therapy. The guidelines outlined particular art therapist actions within the group such as: asking service users to explain their intentions for their picture before inviting comments from other group members; focus on images; the need to look at each picture within the session and not to leave anyone out; and the use of transference in the here and now. In the guidelines for the art therapy group, emphasis was put on the need to mentalize the artworks by exploration by both the individual and other members of the group explicitly describing their viewpoints. These described an active transparent therapist style which is essential to how “Art therapy appears to be a safe method of exploring the mind in the presence of mentalizing self-objects." (p. 14). Limitations of the guidelines were that they drew only on theoretical conceptions and not a wider range of evidence from research studies or professional consensus methods.

Kasuistik (2006) used therapist-reported case study to describe how a service user found art therapy particularly beneficial in helping her externalise her issues into visual

form so that she could then re-integrate the issues. Kasuistik saw a link between the service users's increased coping with her childhood trauma and the creation of her images. The paper was concerned more with justifying this claim than with describing how the art therapist acted to support the positive outcome.

Franks and Whitaker (2007) combined therapist-reported case study, CORE-OM & Brief Symptom Inventory to described art therapy as a part of a mentalization program for people diagnosed with borderline personality disorder. They felt the art therapy offered advantages because "pictorial content is accessible to the group's view, allowing mentalizing experiments with visual perceptions of themselves and others to occur." (p. 14). The authors claimed this process might be on occasions safer than verbalising such perceptions: "Our clients created a visual language and entered a visual dialogue, often unspoken, both with ourselves and others, and then tested on the group." (p. 15). These are valuable insights into what the involvement of other people with similar issues in an art therapy group might offer a service user struggling with borderline personality disorder. A limitation of this paper for the present study was that there was little description of how the art therapists acted. One intervention was described where the therapist asked if the service user was "looking for love by coming into the group." (p. 13). However, such an intervention appeared to be a meta-level, insight orientated interpretation into (possibly unconscious) motivation which appeared to be contradictory to the mentalizing approach advocated. However, it was clear that the therapists were very active in facilitating the means for service users to share their perspectives as a central mechanism.

Persons (2008) explored service user valued outcomes and opinions on mechanisms in art therapy using content analysis of service user interviews. The paper gave practice description of a directive form of art therapy. For example when a service user described themselves as "bloodied and injured" the art therapists directed them to paint themselves

being cared for by a "maternal figure" (Persons, 2008, p. 435). Another service user who had abused women was likewise directed to paint images of women with who possessed feelings and personhood. It would appear that the service users emphasised the importance of the way the art therapist had treated them when directing them, which was to be encouraging and not "putting them down". This appears to strengthen a link between communicating support which encouraging the use of art as a means to generate new perspectives, much like the notion of thinking with things.

Huckvale and Learmonth's (2009) therapist reported case study was highly valuable in offering clarity about what they did as art therapists. They described an approach which avoided psychoanalytic interpretation or “amplification of symbolism” and where supporting the art making by offering suggestions was encouraged (Huckvale & Learmonth, 2009, p. 58). They claimed the approach gave a validating meta-communication to a very fragile service user by providing “constructive diversion” (p. 58). In doing so this helped lower distress and as the service user said: “The painting group is the only space where the voice telling me to kill myself doesn’t intrude." (p. 59). The authors suggested that art-making was an opportunity to organise thoughts and feelings on the page. The art therapist would actively attend to this process, giving detailed, joint attention to the process in therapy. They also gave homework which would be brought back for review. An agoraphobic service user was directed to paint maps of where she would be going in order to prepare emotionally for the event of going there. This appeared to help her to go out and not feel traumatised.

Springham (2010) therapist reported case study described work within a substance misuse treatment centre where a high number of addicted individuals also met criteria for borderline personality disorder. In thinking about barriers to treatment posed by personality disordered attachment styles, the paper drew attention to a longstanding idea

that using artworks in therapy might offer service users the means to regulate the distance between therapist and themselves through the artwork. The earliest examples of this construct were Albert Puleo (1980) in the field of addictions and Lachman-Chapin (1979) when discussing narcissistic defenses. The study argued, echoing Greenwoods point, that overcoming barriers to relationship was a feature of work with people diagnosed with borderline personality disorder too. Artworks functioned as self-objects: material objects in the world which were perceived to be highly referential of an individual's subjective reality. The art therapist offered a highly structured, turn taking approach. Images were considered explicitly in terms of the maker's mental states and the discussion in the group centered on what the artist intended. After the maker described what they had made, the viewers in the group were invited by the art therapist to give their impressions. It was essential that the art therapist stated their view as merely another perspective and not an authoritative truth. The structured approach was justified on the basis that it could not be presumed that service users who know how to use help in the interpersonal pressure of a group setting and that the art therapist had a role in showing that it could work.

Significantly, borderline personality disorder diagnosed service user reflection often revealed that they greatly value art and wished to continue post art therapy (Melliar & Brukha, 2010; Turner et al., 2011):

> "Participating in creative and arts based social activities offers a level of stimulation that distracts from the pain of 'being together'. Meaningful connections are nurtured in what is described as 'attachment to art' and attachment through art'. These processes provide an experiential focus for conversation that helped people to stay engaged whilst lessening the impact of their social isolation." (Turner et al., 2011, p. 342).

Whilst this supports the idea that art can equip those diagnosed with borderline personality disorder to be with others, the papers were not able to shed light about how the art therapist might facilitate this.

Van de Broek et al., (2011) explored the use of arts therapies (art, drama, music and movement) with service users fitting a cluster B diagnosis (of which 30 - N=3 were borderline personality disorder) in a forensic setting. Using a schema focused therapy approach they randomised 10 service users to treatment as usual (verbal) or schema focused arts therapy. Analysing videotape and using multiple raters they identified that arts therapies tended to evoke more healthy vulnerable emotion types of states compared to verbal therapies which tended to elicit more compensatory or defensive types of states. The study's strength was the use of direct observation of art therapy. The small sample size was acknowledged, as was its pilot status, and justification was offered for validity based on the number of raters. However its limitations to the present study were that the focus of observation was on the service user reaction rather than therapist action. Moreover the study did not differentiate the various forms of arts therapy and it was unclear whether the people diagnosed with borderline personality disorder received art, music or drama interventions.

Morgan, Knight, Bagwash and Thomson (2012) undertook a focus group study to discuss the utility of art therapy for people diagnosed with borderline personality disorder from their own lived experience as service users with the condition. The authors highlighted the value of art in therapy in offering a third position for relating, where exploration was less intense for the service user but equally offered the chance for emotional interaction to begin through its exploration. They also highlighted the value of art making for addressing the experience of emptiness: "When feeling blank and detached an "on-paper" representation of emotion can help in reconnecting with one's self." (p. 95).

They cautioned that some art therapists had pursued the existential issues raised in the content of their art work, “connecting with inner demons” (p. 95), and it had a detrimental effect. They suggested art therapy approaches which focused on processes (of art making and interpersonal discussion of the user’s view of artworks), rather than on “insight” into the unconscious content of images from the therapist helped more. The authors suggested that exploring the importance of art making as respite from emotional turmoil would be a useful avenue for future art therapy research. An important issue raised by the study was that many service users found the feeling that their art was not good enough was a constant and difficult theme, even though they were reassured otherwise. This linked very much with existing low self-esteem and the authors recommend that the way art therapists approached that area could be a fruitful area for future research. The art therapy service user's perspective was particularly valuable in confirming particular aspects of theory that art therapist have offered.

Eastwood (2012) offered a therapist reported case study which described treatment for people diagnosed with borderline personality disorder in a feminist based art therapy framework. The approach was characterised by the notion that “the personal is political” (p. 102), linking feminist theory to clinical practice. Eastwood drew direct parallels with the fact of the majority of those diagnosed with borderline personality disorder were female, many of whom had suffered extreme traumatic sexualisation in their development, with the roles and models given to women in society for the individual to make sense of their experience. Eastwood advocated addressing the power dynamic with an egalitarianism stance where the therapist was a non-expert in the service user’s condition but also acknowledged the power differential between service user and provider. The paper described art therapy practice. The group silently made art for 45 minutes. This was followed by a discussion based on service user led art exploration, not based in turn-taking

because it allowed some service users not to speak about their art work if they so chose. The sequence of interactions described was that the artist commented first with group members commenting on the art work after that. It was the art therapist's role to manage the boundaries of time. Eastwood described her verbal interaction as "I wonder aloud about these (service user described) feelings in relation to her image." (Eastwood, 2012, p. 104). This is a very clear description of what an art therapist actually says. The nature of it is mind-focused, firstly on the interest of the therapist and secondly to the mental and affectual state of the service user.

Eastwood also linked the actions involved in art therapy to her understanding of the borderline personality disorder condition. She saw the art as: "(...) a safe place to meet others or to retreat." (Eastwood, 2012, p. 112) and as a "gate" to either close and protect or open and go through. In this way the choice of communicating feelings was placed under the service users' discretion. These mechanisms were employed in direct response to the potential for identity diffusion in borderline personality disorder, where the service user might easily loose a sense of themselves during interpersonal interactions in the group. Eastwood advocated careful engagement with the image so that the art therapist did not to pull the person diagnosed with borderline personality disorder too far from their own representations by making interpretations forcefully. Eastwood also describes the art therapist privileging links to feminist theory for the service user, such as when a service user spoke about her past experience and described having had awful things done to her. As she did so she looked silently down at her own body and the therapist asked directly if she was commenting on her femininity and body.

Springham, Findlay, Woods and Harris (2012) study combined thematic analysis of service user interview; borderline personality disorder Severity Index, Distress Tolerance Scale & Employment. It gave a clear description of the approach used in the art therapy

group. The study involved an interview with one of the authors as a service user in that group who had benefited as rated on a range of measures, asking what helped and what should be avoided in art therapy treatment of borderline personality disorder. This identified eight themes.

1. Art replaces the words the service user can't find
2. Joint attention in art therapy is enhanced by homogenous group composition
3. Therapist models the application of inquiry, rather than pre-determined knowledge to exploration of artworks.
4. Service user to service user comments on artworks supports capacity to accept multiple perspectives
5. Continuous movement between art making and sharing artworks develops emotional regulation
6. The unresponsive therapist is iatrogenic in borderline personality disorder treatment
7. Art Therapist's "watchful, not watching" stance during art making supports immersion in art making
8. Art therapy can be used as self help

These findings were linked with similar service user research in Norway and the USA. The authors suggested a picture was emerging from combining the service user research of art therapy in borderline personality disorder. That was that people diagnosed with borderline personality disorder found art therapy offered unique flexibility of approach which helped to slow down the process of thinking within an interpersonal context of the group to a manageable pace when needed. A recursive process of going back and forth between *art-making* as a means of anchoring mental content in an externalised form and *art-sharing* to introduce that mental content into the group

relationship. This appeared to help the service user develop a reliable and coherent sense of herself and what she wanted to say in the group, which generalised to her life. The eight themes continued to support the importance of an active therapist who manages joint attention carefully and specifically cautioned against unresponsive therapist.

Springham, Dunne, Noyse and Swearingen (2012) outlined the development process of a UK professional consensus guideline for art therapy with service users who had the condition of personality disorder as developed by the British Association of Art Therapists personality disorder special interest group (BAAT PD SIG). The Delphi cycle method consulted 30 UK specialists and resulted in a ten point guide, but not all items refer to therapist action as some are concerned with structuring therapy within a context. Where the guidelines did refer to therapist action they highlight the following: The art therapist devises an explicit therapy formulation created with the service user and pays specific attention to endings, transitions and timeframes. The art therapist promotes art as a central focus of therapy on the assumption it represents an externalisation of different states of mind. They support physical making activity in order to aid affect regulation and attention control. To create shared attention the art therapist focuses on the art objects in order to start verbal enquiry. The art therapist actively ensures communication is comprehensible to the service user, avoiding too much silence, interpersonal ambiguity, complex use of metaphor or interpretation. The focus is predominantly in the here and now and it is important to not support repetitive pre-occupations by focusing into the past. They operate transparently as possible, starting with a discussion to understand the intention of the art-maker but then introduce other's views, offering their genuine responses to artwork and events in therapy in the service of therapeutic communication. Risk is likewise tackled openly. This echoes a number of points raised by Johns & Karterud (2004) but add greater specificity about how the art therapist interacts.

Davis (2014), a person who received a diagnosis of borderline personality disorder diagnosed service user who had undergone described her journey through art therapy using her image entitled “My brain as a washing machine with crockery in it." (Figure 12).

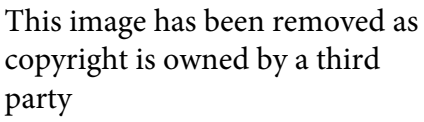

Figure 12. "My brain as a washing machine with crockery in it." (Davis, 2014, cover)

She described how she chose this image for an Audio Image Recording of her art therapy experience because it vividly described an alexithymic state where her mind and feelings spun. As per the service user description by Springham, et al 2012 the approach the art therapist offered was one where art making slow down the spinning so that she could focus attention. She became able to name feelings through listening to other group members describe her pictures back to her in the light of their own experience. This helped her to connect to other people and allowed greater control over her feeling states.

Discussion of art therapy and people diagnosed with borderline personality disorder literature. Given the number of people in receipt of a diagnosis of borderline personality disorder in mental health services and that art therapy appeared to be used widely in its treatment, there were surprisingly few papers which addressed the subject of

art therapy in relation to this condition. It was possible that because a great deal of art therapy was delivered within multi-input treatment programmes it was harder to isolate its effects. Outcome data from MBT RCTs for services which had art as therapy involved in them showed improvements in interpersonal functioning, but these effects had not been studied in relation to art therapy as the sole intervention. However, the Norwegian studies added much to the body of knowledge about art therapy in this area by asking service users to differentiate its effects. This strongly emphasised the use of having an external representation of mental states which could be explored in a structured non-judgemental way.

Most exploration of the therapeutic mechanisms of change in art therapy for people with a diagnosis of borderline personality disorder had predominantly employed therapist-reported case study. Latter this methodology was combined with service user interviews and standardised outcome measures. Whist some studies indicated improvements in borderline personality disorder symptoms no control based outcomes studies had been attempted. Observational methods were used once by Van Broek et al., (2011) but this has been to establish adherence to the schema focused therapy model across a range of arts therapies and not for direct exploration of art therapy. The lack of observational methodology was a deficit because that approach might identify specific actions and processes in art therapy which were less likely to be identified through either self-reported case studies or quantitative approaches.

Some consistencies emerged from the literature about the approach of art therapists to people with a diagnosis of borderline personality disorder. All art therapists treating people with a diagnosis of borderline personality disorder retained the egalitarian ethos long held in the wider art therapy profession, regardless of the condition being treated, seeing their intentions as collaborative and not as experts dispensing insight. Yet art

therapists always attempted to link their approach to the experiences of people with a diagnosis of borderline personality disorder they were treating specifically in terms of the chaotic interpersonal functioning and potential for easily provoking highly disturbed mental states through therapist-service user interaction. This was in marked contrast to the group analytic art therapy and group interactive influenced approaches to art therapy used in MATISSE which assumed higher levels of self-regulation and interpersonal collaboration as a starting point. Where group analytic models were centrally concerned with encouraging self determination through the therapist's non-action in supplying structure, specific art therapy for people with a diagnosis of borderline personality disorder tended to offer structure by giving a time allocation (but not themes) for art making and then exploring images through turn-taking.

Art therapists typically described the role of artworks as externalizing internal subjective reality into a physical form and this was consistent with the both the view of non-art therapist professionals (Johns and Karterud, 2004; Bateman & Fonagy, 2004) and borderline personality disorder service users (Karterud & Urnes, 2004; Morgan, Knight, Bagwash & Thompson, 2012; & Springham, Findlay, Woods & Harris, 2012). For some the physical act of making art involved some level of emotional processing even when service users were emotionally dysregulated (Fonagy, 2012; Springham, Findlay, Woods & Harris, 2012). This could involve organising attention to feelings or "constructive diversion" from feelings (Lamont, 2004; Huckvale & Learmonth, 2009; Morgan, Knight, Bagwash, & Thompson, 2012).

The notion of using art to increase attachment was utilised by many art therapists. The triangular relationship was viewed as offering a buffer against the face-to-face relationship difficulties which normally disrupted attachment in adult people with a diagnosis of borderline personality disorder. This concurred with the conceptions of some

service users who found using art facilitated a less injurious way of being with people. Art therapists and service users agreed that the production of artworks as externalization of mental content could not be regarded as inherently safe or helpful in art therapy with people with a diagnosis of borderline personality disorder.

Where art therapists described a psychodynamic approach their role was to make the artwork safe by containing the interpersonal disturbances of their service user. The psychodynamic formulation offered little to illustrate how they performed that containment other than by being internally reflective of changes in their own feelings and thereby not “acting out.” This self-reflection featured in later non-psychodynamic papers but was not offered as the central or sole action. Service users appeared to value the outcome of that containment but described the action more typically as not being judged in the moral sense of the term.

Service users and non-psychodynamic art therapists agreed that a focus on process rather than content was helpful in making images safe. Typically this was through slowing down the interpersonal processes around the discussion of the image, involving what might be termed explicit mentalizing, and not "connecting with inner demons” (Banks, 2012; Morgan, Knight, Bagwash, & Thompson, 2012, p. 95). Non-psychodynamic art therapists did not engage in interpretation of unconscious material, but aimed to support the service user to define their own narrative of their artwork within a complex interpersonal context. Within groups the art therapist prioritised peer review of images by service users over the therapist interpretation of images (Michaelides, 2012; Persons, 2008). In terms of using art to improve attachment, both service users and art therapists referred to art being a “mediator”, or a “gate”, allowing the service user to take control of how much they offered of themselves into the relationship (Springham, 2010; Turner et al., 2011; Eastwood, 2012) and this related to a long tradition of theorising art therapy

(Albert-Puleo, 1979; Lachman-Chapin, 1980). This could result in a more authentic sense of self in relationships and a reduction in identity diffusion (Van de Broek et al. 2011; Brooker, 2012; and Springham, Findlay, Woods & Harris, 2012). Art therapists saw the continuous movement between solitary art making and exposure to the interpersonal realm of either the individual therapist or the group as the key therapeutic element.

There were otherwise few references to mentalization, possibly because the terminology was relatively new or unknown to many therapists. However some art therapists appeared to be describing mentalization aims in terms of organising thoughts and feeling through joint attention (Isserow, 2008; 2011; 2013). This corresponded with the core principles of the triangular relationship in every circumstance, even where the term was not used. Within the triangular relationship art therapists encouraged service users to take risks in their art where depicting thoughts and feelings. This has been referred to as "mentalizing experiments" (Franks & Whitaker, 2007, p 14).

Summary of Chapter Two and Three

The first part of the literature review outlined how the major art therapy models which identified the art therapy triangular relationship were all non-condition specific approaches. This second part examined how art therapy had been described as a condition specific practice in relation to people with a diagnosis of borderline personality disorder. In both a lack of practice description was evident. More latterly art therapy studies using outcome measures showed some degree of promise that improvements in interpersonal functioning and distress tolerance might mirror those of the MBT RCTs (Whitaker & Franks, 2007; Springham, Findlay, Woods & Harris, 2012).Operationalising art therapy theory for research was therefore identified as a priority. Operationalisation required the development of terms so that they could be communicated between various communities involved in a study. Comparable forms of psychological therapy had integrated other

forms of research to help them operationalise for effectiveness research more successfully. The next chapter examines these, with particular emphasis on observational research, in order to examine their potential for art therapy.

Chapter Four: Alternative Models of Theory Building in Psychological Therapy

I was interested to explore strategies to theory building beyond self-reported case studies which might better support effectiveness research and so turned to the literature on that subject. I invited Peter Fonagy to give his opinion on potential directions for art therapy research. Fonagy compared art therapy outcome research to the early trails in psychoanalysis, which initially revealed little. He recommended that, given the progress made by comparable therapies in that area, a focus on practice would most productively contribute to the readiness for effectiveness research:

> “The evaluation studies are essential, but they will not succeed without some hypothesis about a better understanding of what is inside the “black box” of the therapeutic consultation. To me art therapy has possibly more to contribute to answering this question than any other traditional modality." (Fonagy, 2012, p. 90).

This chapter therefore explores what art therapists might learn from those in comparative fields in psychological therapy who sought to open the “black box” of clinical practice. Observational research was given particular attention for its value in developing taxonomy because it describes practice from the *outside*. Art therapy has traditionally described practice from the *inside*, from art therapist self-reflections. Observational research literature in art therapy was examined and revealed that it has been neglected relative to both verbal and other arts therapies. The argument that the observation of art therapy may present particular challenges both in pragmatic and epistemological terms was examined. Given my social constructionist epistemology, the issue of who observes in observational methodology was also explored. This chapter concludes with a rationale for the approach taken in the present study.

Search strategy. The search question was: How have comparable psychological therapies built descriptions of practice beyond the use of self-reported case studies? The search terms were: “Psychological therapy”; “psychotherapy”; “psychoanalysis”; “therapy”; “art therapy”; “art psychotherapy”; “creative therapies” and “arts therapies”. “observation”; “video”; “audio”; “recording”; “service user”; “client”; “customer”; “consumer”; “interdisciplinary”; “perspective”; “process of change”; “practice description” were each coupled with the terms: “research” “theory building approach”. This yielded 182 studies. In addition I put an email call-out to the UK Art Therapy Practice Research Network for recording approaches to art therapy which resulted in six references. However, these results were not research studies but promotional videos.

Observational Research in Psychological Therapies

Reliance on therapist self-reported has been noted as having been dominant in other psychological therapies but critics found it to be liable to a number of weaknesses. It had been argued that self-report methodology in psychological therapy did not take account of problems of narrative smoothing (fitting observation to a pre-existing explanation), poor memory or unreliable self-witnessing (Alpert, 1996). A review of 43 of Sigmund Freud’s cases between 1907 and 1937 showed that his methods deviated from his own recommendations in terms of three key areas of anonymity, technical neutrality and confidentiality (Lynn & Vaillant, 1998). Accounts by Freud and others from that time showed that Freud frequently discussed his own opinions, directed, spoke about treatment and had extra analytic relationships.

Greenberg (1991) described a paradigm shift in the world of psychotherapy research towards the study of sequentially patterned change episodes. This shift attempted to move from concept of the therapist as the container of expert knowledge to an understanding of what good therapists do. The emphasis on process research aimed instead to make explicit

the implicit knowledge and skills of the experienced clinician so that performance could be compared (Greenberg, 1991). This discovery-orientated approach viewed research as a recursive process, beginning with observation and interviewing and leading to model-building and theorising which was then refined and verified by further observation (Greenberg, 1994; Rhodes & Greenberg, 1994). Videotaping was a common method of observing psychological therapy because it was considered less intrusive than having another person present in the therapy session (Alpert, 1996). It was also increasingly used as a qualitative research methodology (Ratcliff, 2003) including arts and health research (Clark, Prosser & Wiles, 2010).

While much attention has been paid to the outcomes of various types of therapy, observational research tends to compare actions within therapy. The task force for a Common Language of Psychotherapy was an international collaboration which began in 2009. It involved numerous researchers across most of the major disciplines in psychotherapy and aimed to look systematically at the taxonomy of psychological therapy practice. The Common Language of Psychotherapy task force was described as a response to Goldfried, Raue and Catsonguay's (1998) call for terms which might facilitate comparison across the whole field and so put it on a more scientific basis. The Common Language of Psychotherapy task force aimed to build practice descriptions which eschew *a priori* theory. The Common Language of Psychotherapy approach was to: "(...) describe in plain language what therapist actually do, not why they do it," much like a fly on the wall would see the process (Marks et al., 2009, p. 7). Numerous authors within the Common Language of Psychotherapy task force teased out procedures in cognitive behavioural therapy and psychodynamic-interpersonal therapy treatments and found authors often gave varying names to similar procedures and categories. However, a limitation of the Common Language of Psychotherapy practice was that practice

descriptions still relied on therapist self-report. Fly-on-the-wall descriptions might be better derived by observational research.

Tronick (1998) was particularly to draw parallels between psychotherapy and attachment theory (Bowlby, 1952). Given the developmental premise of psychotherapy, a benefit of recordings of actual therapy practice in naturalistic settings was that actions in therapy might be compared directly to recordings of infants observed by ethnographic methodology in attachment theory (Bowlby, 1953). This offered the opportunity to deepen understanding of the communication systems involved in psychological therapy.

Objections to observational methods for psychological therapy. Gill, Simon, Fink, Noble, and Paul, (1968) noted that even though recording technology had advanced since Freud's time, research into psychoanalytic practice was lagging behind comparable therapy fields. They noted Freud's epistemological objection to observation: "[Psychoanalytic] treatment brooks no listener; it cannot be demonstrated … [the patient] would become silent as soon as he observed a single witness to whom he felt indifferent." (Freud, 1963, p. 63). They undertook a study which involved audio-recording individual psychoanalytic therapy sessions to test that theory. They reported that patients readily volunteered to be recorded and were not silenced. They then explored the argument that "silence" may not be literal but a reference to a more selective silence, where free association became inhibited. However, therapists rated the recorded sessions as normal in these terms and not different to non-recorded sessions.

Gill et al.'s (1968) study highlighted that it may be professional attitude that may inhibit psychological therapists engaging in observational research. This conclusion was replicated in a study of cognitive behavioural therapy where audio recording has long been used for supervision, training, and as part of therapy sessions. Shepherd, Salkovskis and Morris, (2009) sampled 72 users of an anxiety disorder service and 90% of service users

found listening to recordings of their own therapy helpful and most planned to keep the recordings after therapy. By contrast their therapists were much more likely to express concerns about the recordings causing distress to those same service users. Forty seven percent of therapists agreed (and 27% unsure) that it made them uneasy that other professionals would listen to their recordings even though 93% strongly disagreed that "therapists should be fully trained not to require the use of recordings in this way." (p. 11). Professional concern about recording appeared to be primarily determined by relationships between professional peers.

The above issues were very pertinent to art therapy. Therefore the prospect of introducing an additional element for the purposes of research, such as observation, an interviewer or even questionnaires has been viewed as threat to therapeutic effectiveness. In discussing her art therapy practice within the public sector, Dudley (2004) attempted an ethical justification for sealing the art therapy experience:

> "One way to preserve my speciality is to protect the therapeutic alliance so important to art psychotherapy, and so I try to maintain as much of the confidentiality of that system as I can. In actuality I end up breaking it every day, perhaps just by feeding back a sentence or two at a case meeting." (p. 17)

Fonagy (2000; 2001) noted the insights gained by psychoanalytic method had been viewed by some analysts, including the founder, as incompatible with scientific methods: "One of the claims of psychoanalysis to distinction is, no doubt, that in its execution research and treatment coincide." (Freud, 1958/1912, p. 89). This resulted in a lack of cross referencing with other areas of science. Wolff (1996) argued against child observational studies for psychoanalysts claiming only facts gathered by psychoanalytic methods (i.e. free association) should be admissible to psychoanalytic theory. Art therapists likewise described the "spotlight" of research as an intrusion into the "esoteric"

essence of art therapy: “(...) as a potential theft of something precious; rather like researching love or religious experience, it seems an affront to the nature of the work that we should attempt to apply measures and methods.” (Schaverien, 1995, p. 25).

Kvale (1996) identified a risk of video as a methodology in psychology being that it might objectify the subject being observed. Likewise art therapists Dolphin, Byers, Goldsmith and Jones (2014) caution that: “There are losses as well as gains bound up in the use of video. The ‘triangulation’ is enacted in the manifest world and goes outside of the session rather than remaining a symbolic process within the session." (p. 142). In reviewing this book Thorne (2013) suggested many of the ideas seemed to return to an earlier point in art therapy theory building. Reflected back on the psychodynamic essence of his art therapy training at that time he summarised that “The idea that it is not what you do, but what you manage to stop yourself doing that may ruin the interaction." (p. 29). A study by Patterson, Crawford, Ainsworth, and Waller (2011) identified another form of limitation attributed to art therapists who practiced in the psychodynamic frame, namely that not all therapeutic action can be observed or described as an observer might be able to recognise. In this study, some art therapists described a high reliance on invisible actions, such as processing counter-transference: “[Art therapists’ practice] suggestions were grounded in both observable action and hypothesised internal experience of the participant and their mental process within the therapeutic frame." (p. 77). This usefully encapsulated the psychodynamic objection to observational research in art therapy that the important aspects of art therapy may be the invisible ones.

As stated earlier, given the present study's social constructionist epistemology, in exploring observational methodology I was interest to understand not only how observation was used but also who those were that counted as observers.

Service user perspective in mental health research. In his introduction to the 2004 Cochrane review, the seminal work on evidence based medicine, the late professor Silagy referred to the lack of service user involvement in health research as the "post-Cochrane challenge" (Silagy, 2004). There was a growing call for a broader, multiple-research paradigm for mental health that encompassed both professional and service user evidence (Bracken & Thomas, 2001; Clark & Chilvers, 2004; Rose Thornicroft & Slade, 2006). The American Psychological Association, Division 29 task force on psychotherapy relationships identified the need to research the process of developing the therapeutic relationship through methods that included the service user perspective (Norcross, 2002).

Service users have identified a need for psychological therapy research to examine both effective psychotherapies as well as how to recover from the possible damage psychotherapy can cause (Rose, 2008). A study by Perren, Godfrey and Rowland, (2009) used grounded theory analysis on a sample of 56 service users who had received different types of counselling and psychotherapy found service user valued outcomes differed from professional outcomes. The study suggested generic interpersonal skills such as creating a good fit and adaptability were more important than the therapist model. Janzen, Fitzpatrick, and Drapeau, (2008), in an interview based study of 30 participants using attachment theory criteria, found that service user nominated critical incidents were a reliable source for positive relationship building criteria. Many studies indicated service users and professionals differ in their views about what makes an effective therapeutic relationship both in quality and in strength (Bachelor & Salamé, 2000; Fitzpatrick, Stalikas & Iwakabe, 2005; Tichenor & Hill, 1989). Horvath and Bedi, (2002) and Horvath and Symonds, (1991) claimed service user judgments about the strength of the therapeutic alliance were stronger predictors of outcome than therapist judgments.

Co-production was an emerging model of service user involvement in research which aimed to integrate user and provider perspective without losing the essential differences between them:

> "[Co-production] involves the close interaction of many actors throughout the process of knowledge production and this means that knowledge production is becoming more sociably accountable. Overall, the process of knowledge production is becoming more reflexive and affects at the deepest levels what shall count as good science." (Gibbons et al., 1994, p. 4).

Gillard et al., (2010a) reflexive study of a service design in a south London NHS mental health trust found that success occurred when neither side moved to adopt the perspective of the other. Analysis of the multi-viewpoint was captured by Averill's (2002) system of matrix analysis. Gillard et al., (2010b) looked at the evidence of impact in using both service user researchers and university researchers in an investigation of the experiences of detained psychiatric patients. Using content analysis they found that there was both a different emphasis in secondary questions during the interviews and coding analysis of the transcript interviews. Service user researchers were more likely to code interview transcripts in terms of interviewees' experiences and feelings, while university researchers coded in terms of processes and procedures related to detention.

Critics argued traditional health research methodologies are inherently biased towards professions and that because co-production requires methodologies it could be dismissed as tokenistic (Turner & Beresford, 2005). However, supporters argued that its validity rests on its ecological or real world fit.

Whilst arts therapies and creative activities were valued by many service users (Lloyd, Wong & Petchkovsky, 2007), service users stated that greater research into arts and mental health should be a priority (Thornicroft, Rose, Huxley, Dale & Wykes, 2002).

The following section of the present chapter now examines examples of service user involvement in art therapy research.

Service user contribution to art therapy theory. Nowell-Hall (1987) was the first art therapist to involve user feedback in her retrospective study of a therapeutic community (this study has been reviewed in chapter two). Turnbull and O'May (2002) undertook a questionnaire based approach followed up by semi structured interviews to ascertain GP and service user views of art therapy in a primary care setting. GPs and service users saw the intervention as effective but there were marked differences between how the art therapists, the GPs and service users viewed the drivers of change, particularly in relation to the term psychodynamic, which was important to the art therapist but less so to the other two groups.

Co-produced papers existed in art therapy literature but they were few in number. The early work by Dalley, Rifkind and Terry (1993) described three voices of art therapy: art therapist; patient; supervisor; who each gave a description of the same therapy. They agreed across the board that the relationship to the therapist facilitated greater creative and mental exploration. More latterly Shaer et al., (2008) described art therapy within an art gallery setting from service user, clinical staff and curator viewpoints. Curators and service users were struck by how much personal emotional material was stirred by art works. Springham (2008) described a legal case involving art therapy jointly written with a service user who chose to be anonymous. The experience of the artwork in relation to personal material was overwhelming. White, Bull and Beavis (2009) described an art therapy treatment in a learning disability setting from service user and art therapist viewpoints. In their account the artworks made were used both as a clinical tool and as an advocacy tool, helping other people outside of therapy to understand the service user's experience.

Melliar and Brukha (2010) explored the ongoing experience, from art therapist and service user perspective, that Brukha had of an image made in art therapy after treatment was finished. They found that the artworks meaning progressively changed for the service user as it was seen in different contexts. Learmonth and Gibson (2010) co-wrote about art therapy with physical disability (polio) from art therapist and service user perspective. In a review of the 167 artworks produced in art therapy, both authors identified the therapeutic relationship as negotiated through the art, described as taking risks of being seen through the art as a central mechanism of change. Woods and Springham (2011) explicitly undertook a co-production framework in looking at the experience of an art therapist in a dual role as both professional and service user. Woods' experience of service use offered valuable insights into alliance building on an acute ward and that this learning proved useful for Springham.

The studies which involve art therapy service users in theorisation had occurred since 1987. The literature had also revealed that novel insights might be gained by involving art therapy service users in theory building. Most highlight the importance of non-specific factors, such as being non-judgemental, in the approach of the art therapist (Dalley, Rifkind & Terry, 1993; Turnball, 2002; Morgan, Knight, Bagwash, & Thompson, 2012).

Widening the range of observers of a practice appears to offer value in research. The following section focuses on how such issues had been considered within art therapy literature.

Observational research considerations in art therapy. The first UK collaborative book on research between art therapy and music therapy (Gilroy & Lee, 1995) pointed out that music therapists as performers and art therapists as visual artists had different representational tools and opportunities at their disposal. Performing arts therapies had

been able to usefully exploit the predominantly temporal based characteristic of their art form. For example, Bunt (1985) and Hoskyns (1988; 1995) applied rating scales to video of music therapy as it unfolded. Loman (1990) and Loman and Foley, (1996) produced the Kesternberg Movement Profile as a notation system for analysing movement in dance therapy. This recording approach had integrity with the temporal essence of the art form involved, namely sound, movement and sequences.

Art therapists do a range of different procedures in their sessions. They arrange the room, position themselves when service users paint, observe, interact verbally and some paint too. But a number of art therapists had referred to the non-performance basis of art in therapy (Albert-Puleo, 1979; Lachman-Chaplin, 1979; 1983; Springham, 1998). The interaction between service user and their image exclusive of the interaction with the art therapist has been claimed to be a unique feature of the art therapy triangular relationship (Isserow, 2013). This may be a complication for observational research in art therapy, perhaps “like watching paint dry?” McNiff (1998) suggested that video could be used for ethnological approach to the art therapy studio but also concluded that: “Video tape technology brings us significantly closer to “actual” activity (of art therapy) but it will never totally record the experience." (p. 195). Moreover, another observational method might be required to integrate the visual data of the artwork that resulted from any human interaction captured on video. People move though space and time but a visual artwork has a still surface, even though it exists in time. Video captures movement, but what are the considerations for observing artworks?

McClaggan (1999) suggested that artworks should be *look at* and not just *looked into* by art therapists. By doing so, art therapists gain understanding of the artwork’s formal elements as a communication and not just the narrative elements suggested by the picture. Schaverien (1995) reviewed artworks post art therapy in order to explore her own counter-

transference. Kim, Kim and Kim (2008) and Kim, Han, Kim, and Oh (2011) employed computer scanning technology to look at pattern making in art therapy artworks. Henzell (1995) made a crucial observation about the limitations of isolating the artwork from the relationship context it was made in. Suggesting interpretations were limitless because pictures do not read from one prescribed point to another as per a text or a performance.

> "On the contrary, (artworks) can be moved across in a multitude of directions; there is no one place where our understanding of them must commence or terminate; several elements of an image may be apprehended simultaneously; and their relationship to time and space radically different from that of writing or speaking. As opposed to text which can only be read or heard through in its prescribed sequence, an image can be visited as a *place;* we apprehend it in space rather than through time." (p. 188)

This suggests that whilst the image was integral to the triangular relationship it was made in it had different features from that human interaction. Wood (1984) reflected that triangular relationship involved a time-bound activity (the relationship) around a static image. It was suggested that isolating the image from the context it was made in creates a problem of too many ungrounded interpretations. Springham and Brooker (2013) explored this problem in the development of audio-image recording methodology used in the "reflect interview." This approach asked art therapy service users to choose two images from their time in art therapy as a means of constructing a narrative of that time. Taking Henzell's formulation of art object as place and situating the approach in a phenomenological epistemology, the study linked the reflect interview to psychogeography (Debord & Johns, 1959). An example of this was Bachelard (1968) who explored the lived experience of space in communal parks, observing how people chose their own walkways which deviated from formal paths, defining these as desire paths.

Springham and Brooker linked the service user's description of their image as a way of guiding the viewer's eye on a journey across the place of the image as a desire path.

Other art therapists argued the case for direct observation in art therapy very much in line with observational research in verbal psychological therapy: "An observer in art therapy sessions has the unique opportunity to notice the exchanges between art therapist and client and their responsiveness to each other and the art. From this perspective the researcher can unravel some of the processes that lead to change and that remain unnoticed or mysterious to the participants." (Ball, 2002, p. 91). Given this controversy, it would be useful to explore the observational studies undertaken in art therapy to date.

Observation studies in art therapy. This section will explore how art therapy processes had been recorded and how the observational processes were structured. In doing so, the distinction made by Weiser (2001) between recording as an observational tool (for research purposes) and where it was used as a tool within therapy (not for research purposes) has been observed.

A systematic review of US art therapy, focusing on work produced in the *Journal of the American Art Therapy Association* between 1989 and 2004 (Metzel, 2008), noted research output has increased (Table 5). Having identified eight research approaches the pattern seemed to show a trend away from self-report methods towards mixed methodologies which include observation.

Table 5

Metzel's systematic review of research methodologies.

Approach	1987 - 92	1993 - 98	1999 – 04
Exploration of artwork	6.4%	12.6%	18%
Observation	9.0%	12.2%	20.7%
Academic/philosophical	17.9%	22%	13.1%
Art therapy tests/assessment	11.5%	7.3%	7.7%
Interview/narrative	3.8%	3.3%	5.4%
Case study/vignette	34.6%	25.5%	18.5%
Self study/heuristic	7.7%	8.1%	8.6%
Questionnaires	9.0%	8.9%	7.7%

Of note was the growth of observational methods from 9% to 20.7%, becoming the most prevalent method. The UK journal *International Journal of Art Therapy* published two papers with observational methodology (Poundsett, Parker, Hawtin & Collins, 2006; Tipple, 2003) in the same period. Other studies were published in books in the UK (Evan & Dubowski, 1999; Gilroy & Lee, 1995).

Rees (1995) aimed to examine how spatial intelligence linked with picture construction in an asylum based learning disability setting. She used direct observation with a combination of ethnographic coding based on Tinbergen's (1950) questions (e.g. Why does this happen now? How does this help things? How did it develop in the first place? How it changed over time?) and her own art making specific codes (Which art medium, if any, does the client favour using? What are the placement patterns of the work produced? Does the client actively select colours?). The aim was not to establish if change occurred in art therapy, but to identify intelligence that may have been overlooked. She concluded that profoundly intellectually disabled individuals do show special intelligence in relation to art making and their social positioning in the room.

Sanders and Sanders (2002) performed an outcome study of art therapy in a treatment service for art therapy for youths between the ages of two to sixteen at risk of behavioural disorders in the US. In addition to measuring behavioural changes and

symptom changes, they developed an “Initial Therapeutic Relationship” scale which used a five point Likert scale to measure observations in eight domains as part of on outcome study. These were: eye contact; trust; acceptance of redirection; acceptance of consequences/limits; verbal expression; non-verbal expression. The observations were made at the first session and at the concluding session. Observation was made by the treating art therapist within the session and no audio or video recordings were used. The sample size was N = 97. The authors observed sessions between 12 and 18 weeks and identified a positive change from a mean of 2.9 to 3.9 on all domains, which was statistically significant (P <.001). A limitation of the study was that no external raters verified these outcomes.

Evans and Dubowski (2001) used microanalysis of the first session in art therapy with autistic spectrum disordered children. Their aim was to develop an assessment tool which would incorporate understanding of the behavioural sequences of the particular service user in relation to the art therapist. This drew on the work of Pruznick (1984) who also found that viewing his interactions on video was the only way to see micro-exchanges that distressed the handicapped child. Understanding the behavioural cues which often were not perceivable to the art therapist in the session helped attunement between client and art therapist. Analysis of drawings made pre-and post this intervention showed marked increase in creative exploration beyond the repetitive drawing schema employed by the service user when they arrived in art therapy. The approach showed a novel integration of artwork and relational interaction in method. It did not examine if increased exploration in artwork correlated with an increase in other areas of social function, which was a limitation.

Ball (2002) observed 50 individual child art therapy sessions over a period of one year combined with 11 interviews with the treating art therapist over this time. The aim

was to look at what changed and how change occurred. She used direct observation by sitting in the art therapy session with the therapist and child and made notes, which she developed iteratively into codes. Her codes were split into two sections: Focus of attention (art making and art materials; therapeutic relationship; self (client); outside; observer) and mode of interaction (acting and acting out; symbolizing; observing reflecting; creating new connections and artworks). She shared her descriptions of sessions with the art therapist for verification. In addition her code book was supervised by a team of researchers. Change was viewed as a modification or new direction that made a difference in recurrent interactive patterns. This would include more turn-taking, less help rejecting from the service user. The study noted changes in imagery produced by the child. Changes occurred in the areas of:

- Focus on interaction, from external to internal with more self-references made by the child.
- Mode of interaction, with less “acting-out” and more co-operative meaning making.
- Function of the art process, an increase in self depictions.

Therapist and observer rated change at the same point, with corresponding change in artworks. However the therapist reported that: “I feel change but I don’t know why." (Ball, 2002, p. 79). This supported the original hypothesis that it was hard to self-rate therapist action in therapy. The strength of this study was that it takes an in-depth approach. Its limitations were that it was a single case and external raters did not directly view the clinical sessions.

Tipple (2003) used retrospective observation of his art therapy practice within a paediatric disability setting by reviewing the first session on video. His method of observation was video which was routinely used as part of the whole team’s clinical

assessment and he used this material as data. His aim was to explore “discipline discourses” (Foucault, 1967) within the disability setting in order to look at how: "(…) ideological power can foster an ignorance of contextual pressures which shape art." (p. 58). Tipple offered a single case study where he combined observation of the assessment videos with his own retrospective counter-transference based reflections on the client’s artwork. As an art therapist, he was the sole observer of his work. His conclusion was that the use of art in therapy allowed the development of shared metaphors, rather than therapist imposed metaphors, to aid communication. The limitations of relying on counter-transference through a single study to detect large cultural influences were not addressed in this study.

Poundsett et al., (2006) attempted mixed methodology combining case study and video recording to explore outcomes of art therapy treatment within a learning disability setting. The primary aim was: “To gather effective objective information about changes in the client that correlate with the therapist’s subjective view." (p. 79). The authors used the Adaptive Behaviour Scale (Payne, 2003) and the Mini-PAS-ADD, an assessment schedule for the detection of mental health problems in adults with developmental disabilities (Prosser, Moss, Costello, Simpson & Patel, 1996). A 13 point coding scheme was derived from Play Observation and Emotion Rating System (Wolke, 2001). The sample presented was three case studies. The observers were the art therapist clinicians and cross psychological therapy discipline with inter-rater reliability testing. The study showed a correlation between therapist perception of change and measurable change in pro-social behaviour. The study did not look at artworks produced in art therapy which was cited as a limitation. Arguably the lack of service user observation was also a limitation.

Springham, Thorne and Brooker (2014) undertook an exploratory study which involved videoing themselves whilst taking part in a modified single session of art

therapy. The aim was to explore art therapy both from the inside as per traditional theory building methods of therapist recall and from the outside, by video analysis. All were practicing art therapists and no one of them took the role of the therapist. All aspects of making and discussion of their artworks were video recorded. Immediately upon completing the group they wrote their subjective experience in the form of a reflective log. They then identified moments of trust experienced subjectively and then identified those moments on the video recording. Taking one jointly agreed moment of trust they used the video to explore what identifiable actions could be observed by them that were significant in contributing to that trust. They found that moments of trust involved the accumulation of intense periods of joint attention where art-viewers physically gesturing in ways which mirrored the gestures involved in making the artworks. The review of the video revealed the physical gesturing appeared to contribute to increased intensity in the joint attention but whilst the reflective logs recorded an increase in a feeling of empathy, the physical nature of that gesturing was completely absent. The limitations of this study were that it involved one session with a non-clinical population.

The above studies, whilst few in number (particularly in relation to music therapy for example), offered useful insights into art therapy. They were grounded in a more explicit description of the difficulties and condition the service user brought to the session than the vaguer descriptions of models of art therapy derived from self-report such as group analytic art therapy (McNeilly, 1983) for example. However, most study has not been replicated and relied on single observers.

It was clear that a great deal can be observed about the art therapy triangular relationship but that it was complicated and requires a combination of methods to capture both image and human interaction. Consistently the use of observational methods gave art therapists novel insights into their own practice. Limitations to this body of research are

that it was all practice in individual formats. That practice was exclusively either with children or where there was a development disorder. Poundsett et al.'s (2006) study was particularly strong in seeking a range of perspectives external to the profession of art therapy to verify the observations. However there no service user observations of practice in any studies.

Summary of the Literature Review and Rational for the Present Study

The impact of social constructionism on art therapy theory appears to be minimal, whist the influence on art therapy practice with marginalised groups seems more so. In the present study, the literature review revealed that whilst art therapy studies described their methodological approach it was very rare that they explicitly outlined their epistemological position. Of the art therapy studies which declared an epistemology, none were social constructionist. However, it was possible to infer that the dominant epistemology used in art therapy was psychoanalytic. This was because authors described the *clinical* approach they used in their art therapy practice to be psychoanalytic, with many examples corroborating that by the art therapist engaging actions such as the interpretation of the service user's unconscious motivation. That clinical approach was then described by the art therapist in a case report format. The use of triangulation through different viewpoints or measures in studies as an aid to theory building was, until recently, rare. Instead, art therapists used their interpretations of unconscious motivation to reflexively build art therapy theory, often with explicit references to existing psychoanalytic literature. This conflation of practice and research conforms to Freud's assertion that in psychoanalysis practice and research coincide (Freud, 1933). It was of note that later theorists located Freud's original approach to psychoanalysis as an attempt to gain credibility within a 19th century positivistic culture, with the result that therapist interpretations were taken as truths for the purpose of theory building (O'Neill, 1996).

That conflation has been disputed by latter psychoanalysts (Gill et al., 1969). Yet the dominant strand of psychoanalysis in art therapy theory building over recent decades appears to conform to that earlier paradigm. The assumption that it should be the art therapist's interpretation that formed the basis of theory has arguably done the most to distance it from a social constructionist epistemology.

Art therapy theory developed then can be described as developing through a very narrow approach. The emphasis on defining the practitioner more than the practice and a reliance on self-reported case study produced a limited taxonomy for describing art therapy practice. Likewise most outcome studies in art therapy neglected descriptions of practice. Comparable forms of psychological therapy had benefited from broadening their approach to theory building. Observational research appeared to offer particular advantages because it built practice descriptions which had compatibility with other areas of science, such as attachment theory. The development of descriptions of practice was therefore a research priority for art therapy.

The review of the literature revealed that the experience of people with a diagnosis of borderline personality disorder required a specific psychological therapy approach because the difficulties involved with interpersonal functioning tend to negatively impact on the therapeutic relationship. Art therapists had written about specifically tailoring their treatment approach to people with a diagnosis of borderline personality disorder and a number of more recent studies detailed practice in the mentalization model. However, the mentalization model was predominantly conceptualised as a verbal model and whilst it offered general guidance for practice, it offered little about how art therapist might interact with service users and their artworks in a triangular relationship. Whilst observational methodology had been used to develop mentalization therapy, no such work had been undertaken for art therapy in the mentalization model.

Given observation of art therapy groups had not been attempted, it was possible that novel procedures for doing so would need to be developed. This required a feasibility study to be undertaken prior to the main study. Social constructionism obliged me as a researcher to consider who was involved in any research undertaken. No service user observation had been described in the art therapy literature and this needed to be carefully considered in the feasibility study

The above assumptions formed the research approach in the present study and the following chapters outline the methodology used.

Chapter Five: Feasibility Study

This section aims to outline the procedures and results of a feasibility study. The UK National Institute for Health Research offers the following definition of a feasibility study: "Feasibility studies are pieces of research done before a main study in order to answer the question "Can this study be done?" They are used to estimate important parameters that are needed to design the main study" (The UK National Institute for Health Research, 2012). The National Institute for Health Research parameters for feasibility studies include willingness of participants to be involved; willingness of clinicians to recruit participants; number of eligible participants; characteristics of the proposed intervention; and time needed to collect and analyse data. The aim of a feasibility study was to assess whether a larger study was viable.

I begin the chapter by defining the gaps in the literature about how art therapists had approached observational based approach research for groups. This identified where the development of novel procedures was required to make the study feasible. The chapter concludes by describing how the feasibility study results formulated the procedures used in the man study.

Identifying Untried Procedures Needed for the Main Study: a Gap Analysis from the Literature Review

The triangular relationship refers to the therapeutic relationship between service user, their image and the art therapist and has been claimed as a unique feature in art therapy (Wood, 1984). A review of the literature showed that few research studies had been conducted into how art therapists put the principles of the triangular relationship into practice. In examining a large randomised control trial on art therapy, interviewers found art therapists had difficulty describing their practice in the trial (Patterson et al., 2011a; Patterson et al., 2011b). Comparable psychotherapy schools built practice descriptions

from observational based research (Greenberg, 1991), but observational methods in the UK art therapy profession has been neglected relative to therapist-reported case studies linked to existing theory (Gilroy & Lee, 1995; Metzel, 2008). Some authors asserted that recording the practice of art therapy presents particular challenges in relation to the artwork (Henzell, 1995; McNiff, 1998). Where observational studies had been conducted in art therapy, they had exclusively focused on child and adult learning disability populations (Ball, 2002; Evans & Dubowski, 2001; Rees, 1995; Tipple, 2004) and were limited to individual, rather than group treatments, despite the latter being a common form of delivery for art therapy in the UK. Methods of recording art therapy groups and their artworks would therefore need developed prior to conducting the main study.

With regards to using a range of observers in research, with the exception of Poundsett et al (2006), all studies had relied on art therapist observers. No studies in art therapy had involved service users as observers. Although service user research was developing in mental health generally, it was still uncertain whether enough precedents could be drawn on for an observation study of clinical practice to formulate a safe approach to the standard that would meet approval by an ethics committee. It was possible this issue may be even more pronounced in the area of people with a diagnosis of borderline personality disorder given the pessimism and anxiety the condition had historically raised in professionals. Lastly, another area of uncertainty concerned recruitment of an homogenous sample art therapists, i.e. working in a mentalization model. The literature on art therapy treatment with people with a diagnosis of borderline personality disorder was not extensive and only one study existed taking a mentalization-based treatment approach at the start of the research (Franks & Whitaker, 2007). Moreover, the UK literature offered an anti-observation argument from prominent art therapists (Dudley, 2004; Schaverien, 1995) which may have negatively impacted on

recruitment. Given the lack of previous studies which addressed the use of audiovisual recording and observation in art therapy research, a feasibility study was indicated.

In addition to identifying feasibility issues from the literature, I anticipated that the research ethics committee would require the focus group moderator to possess clinical skills when showing *in vivo* clinical sessions to people with a diagnosis of borderline personality disorder. It was possible that this could trigger difficult reactions in service user participants in focus groups. Because it was such a specialist area in art therapy, it initially indicated that there may be a necessity for myself to adopt two roles in the main study, firstly in submitting a recording of my own clinical practice and secondly in conducting the focus group. The literature on focus groups did reference the potential for such a dual role to occur. However complex demand characteristics were incurred if this approach were taken. The focus group moderator may have an unconscious bias towards favoured descriptions of their practice over others or focus group members may be inhibited or experience pressure to reassure the focus group moderator about their recorded practice (Dubus, 1990; Greenbaum, 1998; Herderson, 2011; Krueger, 1997; Krueger & Casey, 2008). However Krueger (1997) did not necessarily see such problems as a bar to preceding if there was monitoring from external raters:

> "You may not be in the best position to judge yourself. Consider inviting others to rate you. Your rating could be done by a colleague, a mentor, the sponsor or even the focus group. Be flexible and learn what you can from them." (p. 96)

I therefore ran the focus group for the feasibility study on this basis, but was aware that this may create a conflict in the research.

Developing feasibility study research questions. With the above points in mind, I developed the following three feasibility study questions:

1. Is audio visual recording of an art therapy group *in vivo* capable of producing

data for the focus group?

2. Does the focus group format provide analysable data to answer the primary research question?
3. Can the potential for bias created by a moderator's dual role in the focus group be controlled for through external monitoring?

As recommended by Krueger (1997) and Pattern (2002), the viability of the procedures was assessed by seeking respondent validation, using these targeted questions, from the feasibility study participants who took part in both the art therapy group recorded and the focus groups used for observation. I now describe the results of the feasibility study using each of these three questions in turn.

Feasibility Question One: Is Audio Visual Recording of an Art Therapy Group *In Vivo* Capable of Producing Data for the Focus Group?

The first stage of the feasibility study involved developing an approach to recording art therapy groups as would provide suitable data for observers in focus groups to discuss. This would require a means of capturing the often visually complex human interactions between people and with artworks in art therapy groups. Given the uncertainties about how art therapy group members in a clinical setting might be affected by the demands of videoing art therapy group, it was not ethically justifiable to involve active users of services in the initial recording process at this stage of the research. I therefore set up, facilitated and recorded a feasibility art therapy group using staff recruited from within Oxleas NHS Foundation Trust art therapy department. Consent was obtained on the basis the recording would be put into the public domain for the purposes of information, training and research (Appendix C). Such an experiential learning approach was common in art therapy (Gilroy, 1995). Participants received a written information sheet prior to the session. The consent form complied with the Data Protection Act 1998, Oxleas NHS

Foundation Trust policy on the use of digital media and the British Association of Art Therapists code of ethics. Once the session was recorded each art therapist was given a DVD of the group recording in full to view prior to signing the consent form. All members of the group signed consent on that basis.

Prior to starting the feasibility art therapy group participants agreed to reflect on their experience within their role as art therapists and to not focus directly on their personal lives. When conducting the feasibility art therapy group I needed to make adaptations to my approach for the purpose of recording. I arranged the chairs for the discussion in an open horseshoe shape facing the camera, rather than the typical closed circle format. This was to ensure no-one had their back to the camera. When issues to do with the recording of experience were raised in the feasibility art therapy group, I addressed them as any other “here and now” issues as per treatment as normal in the mentalization model.

The feasibility art therapy group was recorded using separate video and audio equipment because the quality of sound on standard video recorders was often poor and may not be effective in capturing group interaction and discussion. A Zoom H2 digital sound recorder was used to capture 360-degree sound. Video recording of the art therapy group required that a great deal of movement in the art room to be captured (i.e. when participants choose a seating position, collect art materials, or wash up). A tripod mounted high definition digital Toshiba 10 mega-pixel Camileo camcorder was used to ensure that visual detail and speech could be picked up clearly. The art therapy environment was an oblong shaped room and it was set up as indicated in Figure 14. This allowed the camcorder to be in a fixed position with a field of view which could capture both art-making and art-discussion.

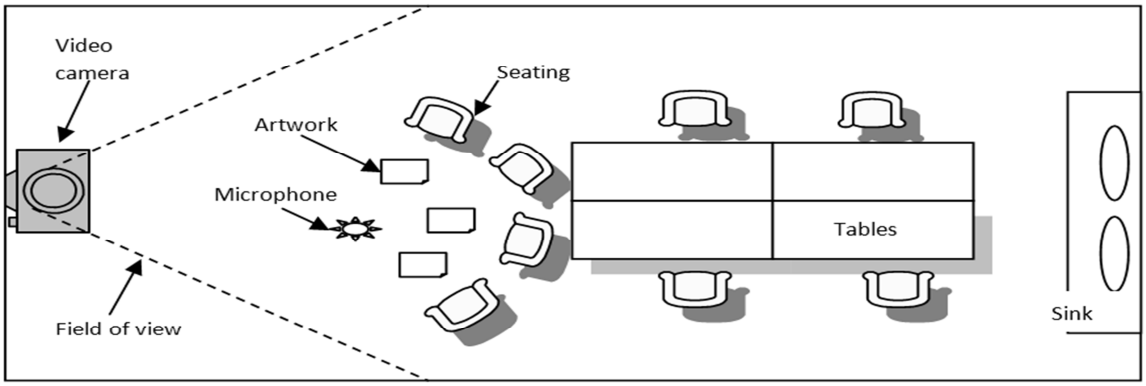

Figure14. Art therapy room layout

On immediate completion of the feasibility art therapy group I recorded a discussion where I asked participants how they had found the experience of the process. They commented that the experience of the art therapy group was both novel (having a camera, working together for the first time etc.) and familiar (it was recognisably a normal art therapy session and had not needed alteration for the purpose of recording). Participants described the session as having involved some level of "live" emotional processing, as even reflecting on the working day in their role as art therapists involved feeling reactions, and as such rated the group session as demonstrating an art therapy process.

Following this I then rendered the digital audio and video files together using the Windows Moviemaker programme. In reviewing the recordings, I found that the fixed position camera had adequately captured all the interaction between members of the group in its field of view. However, the artworks produced in the group were not visible to the observer from that fixed point of view because they were on the floor or on tables and this was a significant loss of data. Artworks were therefore photographed separately. In addition I also rendered a still image of the artwork being discussed with the same audio recording of that discussion. These are described as audio-image recordings (AIRs) (Springham & Brooker, 2013). Both recordings would be played to the feasibility focus groups.

Unsurprisingly for a therapy that involved an art making experience, the video demonstrated very different types of interaction occurring throughout the art therapy session, ranging from silent art making, discussion and even washing up. I reviewed the total length of the video and divided it into eleven sections where a specific task could be described (Figure 15). This might be contrasted with a verbal group-therapy where the whole event might arguably be in one action (i.e. sitting and talking).

1: Welcome participants to the group 	7: Artist describes own work 
2: Interacting with materials and room 	8: Moving from artist to viewers 
3: Settling to image making 	9: Moving from viewer back to artist 
4: End of image making 	10: Moving from one artist to next 
5: Transition to discussion of image 	11: back to whole group to end 
6: Introducing discussion part of group 	

Figure 15. Eleven stages in the group.

I then returned to my research question, which was: How Do Art Therapists Interact with Service Users and their Visual Artworks (The Triangular Relationship) During the Discussion Section of Mentalization-Based Art Therapy Groups Aimed at Treating People with Personality Disorder? I used this question to identify a 10-15 minute time sequence from the total recording where the discussion phase of a particular artwork had taken

place. I found this corresponded to sections seven to nine in Figure 15. And resulted in an eight minutes eight seconds sequence of video where I felt an art therapy process was taking place.

Following the identification of a video edited sequence, and prior to undertaking two feasibility focus groups, I used the feasibility question: "Is audio visual recording of an art therapy group *in vivo* capable of producing data for the focus group?" to establish the reliability of the my research question in eliciting homogenous data. I first presented the video-recorded sequence to the British Association of Art Therapists personality disorder special interest group (BAAT-PDSIG). I later also sought the same verification from the feasibility focus groups. On all occasions, those viewing the video edited sequence agreed that it represented an excerpt of art therapy practice which matched the target of the research question. However, in doing so, the feasibility art therapist focus group and the BAAT-PDSIG were keen to highlight that the research question did not address other important aspects of art therapy, such as "the intensity of the art-making" or other "how artworks or group culture changes over time." I acknowledge this as a limitation of the present study.

I concluded that the recording approach used, and the research question, did provide the data from in vivo art therapy group needed for focus groups. I then went onto develop a methodology for the focus group as a means of generating analysable data as described in the second of my feasibility questions.

Feasibility Question Two: Does the Focus Group Format Provide Analysable Data to Answer the Primary Research Question?

Krueger (1997) defines focus groups as: involving people; the people have certain characteristics; they provide qualitative data; and have a focused discussion. Focus groups have been used increasingly for academic as well as commercial, purposes since the

1980s. Where the purpose of a study is academic and when participants are experts, as in the present study, then reduced size is recommended to gain depth of discussion (Krueger, 1997). Likewise Pattern, (1990) argued, "The validity, meaningfulness and insights generated from qualitative inquiry have more to do with the information richness of the cases selected and the observational/analytical capabilities of the researcher than the sample size" (p. 185).

Focus groups purposefully use communication within groups to help participant's refine their position in relation to each other. Krippendorf (2004) advocated open-ended discussion within focus groups to provide data to subsequently adapt and develop theory. The aim was to gain a range of responses: "Focus groups are not about consensus but about the feelings, comments and thought processes of participants as they discuss the issues" (Krueger, 1997, p. 8). Individual participants may change their minds on hearing other views and the moderator seeks internal consistency by presenting any such change back to the participant and seeking agreement on the final position, noting where opinions are conditional.

Charmaz suggested that focus groups develop a lot of data very quickly and recommended coding from verbatim transcripts of recorded sessions rather than from focus group leader's notes, which tend to miss that richness (Charmaz, 2006). Therefore all feasibility focus groups were audio-recorded and transcribed. The focus group moderator is also concerned with establishing the range of ideas between members, seeking reasons for those differences with active questioning. Analysis of focus groups sought to represent the range of views expressed, attempting to find disconfirming evidence of what first emerges in the group discussion:

- Frequency – how often was it said
- Extensiveness – how many people said it

- Intensity – how strong the opinion (Krueger, 1998, p. 64)

Criticisms of focus groups are that participants may simply make answers up or be overly influenced by dominant individuals; thereby producing trivial results if the subject was too large or complicated (Krueger & Casey, 2008). Advocates countered that such limitations can be controlled through group moderator's skill and the application of checklists for group moderators (Dubus, 1990; Greenbaum, 1998; Henderson, 2011 Krueger, 1998a; Krueger & Casey, 2008). Others have criticised focus groups as generating second class data which is fractionated and unlinked to the research question (Morse, 2001), or contrived (Stern & Covan, 2001). However, the present study did not use focus groups to recall distant experience beyond the time and place of the focus group itself, but instead asked attendees to respond to an immediate experience of viewing recorded sessions in the here and now of the group. I argued that this can mitigate the effect of contrived recall.

Recruitment of participants for feasibility focus groups. The feasibility study consisted of two focus groups comprising service providers and service users. The service provider group was recruited from the art therapists at Oxleas NHS foundation Trust who had not taken part in the art therapy group. The service user group was recruited from ResearchNet (Springham et al., 2011), a group of former service users within Oxleas NHS foundation Trust who formally volunteer to lead and take part in research activity as part of a recovery programme following treatment. The use of ResearchNet met a number of ethical concerns posed by the service user element of the study. All members of ResearchNet had undergone formal interviews to assess their readiness to undertake research roles. All had undergone formal induction, criminal record bureau and NHS occupational health checks, preparatory training, mentoring and had weekly support.

Both focus groups were given an information leaflet explaining that the group was entirely voluntary and I would make a transcript from the audio recording of the feasibility focus group. At the end of the focus group participants signed a consent form confirming they could withdraw from the study at any time.

Feasibility focus group procedure. In preparation for the main study, and in line with social constructionist epistemology, the feasibility study employed focus group methodology in a "multiple category design", which uses homogenous groups, with each focus group heterogeneously different from each other. This assumed analysis benefits from multiple insights and perspectives (Krueger, 1997, p. 26). In the feasibility study this involved convening two focus groups. The first group was analysed and key themes were introduced into the second for verification of disconfirmation.

I undertook the role of focus group conductor. The impact of my dual role as the art therapist appearing on the video edited sequence and focus group moderator on focus group participants was explored in the next feasibility question (three). In the feasibility focus group I asked questions using a semi-structured interval schedule (Table 6) which followed Krueger's (1997) direction of examining "... both intellectual and emotional responses by means of questions which include clear directives and evoke conversation and are open-ended, use appropriate language and are easy to say, are clear, short and are one dimensional" (p. 52).

Table 6

Feasibility focus group interview schedule

Aim	Question
What we are asking focus group participants to do	Everything and anything you notice happening in it is important. I really value understanding why, from your experience, you rate that observation as important.
General observations of art therapy	• What was your first impression of the art therapy group? • Is this what you thought discussion in art therapy would look like? • How would you describe this art therapy group to the non-art therapist reader of this study?
Observations of therapist action	• What would you say the art therapist is doing? • What do you feel he is trying to achieve?
Observations of participant's experience	• What do you think is happening for participants? • Are different things happening for artist and viewers of the artworks?
Observations of therapeutic change	• Do you feel you can see any therapeutic change? • Is it the same for viewers and artists? • How would you describe the beneficial elements? • Any other thoughts?

Immediately upon completion of the above schedule, I asked the feasibility focus group to appraise the interview schedule (Table 6). To do this I used the following questions (Table 7):

Table 7

Feasibility focus group evaluation questions

Aspect focused on	Question
1 Viewing Procedure	• Do you think focus group participants will need to view video and AIR before the group? • Was it onerous to have to watch these beforehand? • Do you think it would be upsetting for service users to look at selected time sequences on their own beforehand?
2 Recording tool	• Do you think we need both video and AIR? • Did you think this conveys enough about art therapy groups?
3 Focus group	• Did my questions help you to answer? • Were they focussed enough?
4 Other issues	• Any other thoughts or suggestions? • How was it as an experience?

The focus groups were both run in the same manner and showed audio-visual material followed by a discussion guided by the semi structured interview. The service provider focus group (art therapists) participants were sent a DVD of video plus AIR prior to the focus group. The former service user (ResearchNet) group was not sent the recording before the group because of the potential risk of disturbance to them in viewing them unsupervised. Both focus groups were given a letter prior to the session which stated the aims of the focus group and the types of questions that would be asked (Appendix D). During the focus groups, the audio-visual recordings were presented in two forms: an audio-visual video recording of the group interaction and an AIR. These two processes were used to pre-empt the difficulty of having so much to look at in the focus group, namely both image being discussed and the body language in the group as people discussed it. The focus groups were run separately and employed a large 17.5 inch laptop with an amplified speaker for the group to view both the video and AIR.

Both the provider and user focus groups had an introduction to the task and then 16 minutes viewing both video and AIR. After this the provider focus group discussion took

24 minutes and the user focus group discussion took 32 minutes. Immediately upon finishing both focus group sessions, each group was then asked to discuss the effectiveness of the focus group they had just experienced using the following focus group evaluation schedule.

Method of analysis for feasibility focus group data. In order to assess whether the feasibility focus group method would produce data which would address the second research question, the I undertook inductive thematic analysis as described by Braun and Clarke (2006). This method was chosen because: "Thematic analysis should be seen as a foundation method for all qualitative analysis" (p. 78) and therefore would offer scope for ascertaining the relevance of data to the research question. Inductive analysis aims for a rich description of data with themes linked to the data itself, rather than an *a priori* theory and has been recommended for under-researched areas (Pattern, 1990). Themes aimed to capture discrete, mutually exclusive, units of description, organised to show patterns in semantic content in relation to the research question. The framework of the analysis assumed a unidirectional relationship between meaning, experience and language.

I familiarized myself with the data by listening to the audio-recordings and taking notes and then produced a verbatim typed transcript from the audio recording using Kvale's (1996) method of including all forms of speech such as *erm* and *ahh*, identifying pauses of less than five seconds using a triple-dot punctuation mark (points of ellipsis). Longer pauses were indicated by a full stop. Emphasis in speech was indicated by underlines words which were stressed by participants. From this, initial codes were manually identified by organising data into meaningful groups in relation to the research question. Codes were then initially grouped into theme piles. The candidate themes were then analysed for both internal homogeneity and external heterogeneity and any additional

data which was did not fit was re-coded. Final themes were then named and presented with a description and supporting verbatim quote. No inter-rater reliability was attempted.

Results for feasibility focus groups. In terms of the viewing procedure, focus groups reported that they needed to see both group interaction and artworks to make sense of the art therapy group, but opinion was mixed about whether they needed the AIR format to view the artworks. For example, providers' greed the need for both video and AIR formats:

> Provider 1: “What I was struck by was being impressed again the second time of how much more that I heard when on the second showing was just focused on showing the image (in the AIR format), there were things that I just didn’t seem to hear when we were watching the group interact.”
>
> Provider 2: “Yeah I agree with that, I certainly found it a different experience seeing the image and hearing the voices (in the AIR format), I felt I could concentrate much more and I think I got a lot more out of it in that way in terms of the process.”

There was less emphasis on the value of seeing the AIR in the user focus group. As one member put it:

> “I must admit that when the video solely of the image was on the screen I did, I was a bit distracted because I was trying to draw my own conclusion from the picture to figure out what it was for me. So that kind of took me away from the discussion.”

Members of user group felt it might have been better for a printed image of the artwork had been used instead of the AIR.

The two focus groups differed in their opinion about whether the level of risk in requiring service users to watch the recordings of art therapy sessions before attending the focus groups. Users felt unanimously that the impact of watching clinical material without a supportive group present could be difficult and unpredictable for a service user.

Providers were mixed in their opinion of this, suggesting that they thought some service users would be able to cope. Both focus groups felt that service users could cope with seeing clinical material only on the condition that they were sufficiently recovered in their mental health. As one user member put it:

> "It wouldn't bother me now if that (the video and AIR of art therapy) had been shown to me, because my mind, I'm in a better place and time in my mind. Two years ago I wouldn't have been in any fit shape to see it."

All participants described the focus group questions as focused and easy to follow. Both groups highlighted that it was useful to have the questions prior to the focus groups in the invitation letter as they perceived that helped lessen anxiety and increase the spontaneity of discussion. They reported experiencing the questions as helping them to verbalise more than they had expected about their perceptions of the recordings. Focus group participants from both groups were unanimous that the service user perspective was very important in addressing the research question. As one user member described:

> "Potentially the service user can look at that (video) if I was in that situation this is how it could affect me. So that again, it's that personal perspective that no one else can bring."

User focus group members noticed that the selected time sequence made them think of their own experiences, such as being on acute wards or in therapy and wondered if this would distract from exploring the specific questions asked in the interview schedule. This was discussed in terms of how service users might over-identify their own experience with what was shown in the recording of the art therapy session. I noted that he needed to employ more focusing interventions within his style with the ResearchNet group to address the drift away from the question about the recording into recounting their own story.

Following the production of a transcript, a thematic analysis was undertaken. Ninety per cent of the items of text were assigned to thematic categories achieving a high level of saturation (see Appendix E for full codings). This resulted in seven themes:

1. Personal connection.
2. Prioritising an artwork focus.
3. Emotion linking.
4. Connecting artworks.
5. Emotional connections.
6. Non art focus.
7. Emotional control.

Description of resulting themes. To demonstrate how these themes were relevant to the research question they are presented in turn below in relation to the specific actions in the art therapy delivery they describe.

Personal connection. Artist increases personal connection to own artwork through others' comments on it. This theme concerned a central focus in the art therapy group discussion to increase the linkages between images and personal associations. This actively included group members attending to those links for the artist. As one provider participant put it: "There was a sharing of experiences and clearly the way the two people who hadn't made the image, erm... seemed to have quite a big influence on the way the art-maker then saw her own piece of art-work."

Prioritising an artwork focus. Therapist primarily encourages verbalisation of group members' associations to artist artwork. The art therapist leads the group rather than allowing a free floating discussion, as one provider participant put it: "The focus was very much on the image ... there was little, I think, ... talk about other things."

Emotion linking. Emotional links did not always exist between image and artist prior to discussion. This theme concerned the observation that so much of what for the artists, would later become credible personal associations to the image were not obvious to them at the start of the process of discussion. As a user participant observed:

> "I suppose I was surprised at the emotion I think that came out…and I think that was a bit how it felt to (the artist). It sounded like she was quite surprised by what happened. That she had somehow expected to be a bit more detached from it."

Connecting artworks. Finding similarities between artworks in the group lessens anxiety for artist. Observers noted that finding common themes or similarities in the images between members of the group brought relief to the artist. As one provider participant noted: "Well I think it must be some evidence of relating and um and if, the ... this activity can promote relating and understanding between people then that's quite a major part of what that (relief) is to do with"

Emotional connections. Discussion of artists' artwork connects other group members emotionally to artist. The group members used their own emotional references to explore the artist's artwork and upon hearing other members associations to the image the artist was put fractionally more at ease:

> "Yeah I thought that worked, that people also were quite free with some of their own associations with it, with the image, which ... didn't feel... I mean at the end she said something about feeling exposed it didn't feel 'exposing'. The things they were saying... they were very much kind of their own" (provider participant).

Non art focus. Finding links between group members without images is important as a second step. Although the main focus of the discussion was directed by the art therapist to the image, the therapist and the group later allowed a broader frame of reference for discussion:

> "I think it was partly a sort of dipping in and a dipping out. Being able to think about the image in terms of their stuff but also thinking about it from (the artist's) point of view and maybe thinking about what it would be if I was in that position. I thought there was quite a lot of empathy" (user participant).

Emotional control. Verbalisation of artwork content aids emotional control for artist. In noticing that art making had raised some powerful feelings for the artist, participants observed that it was by talking about the artwork that these appeared to become more manageable for the artist:

> "What happened was a non-verbal process and it seemed as the film went on that it did relate to the way (the artist) was feeling but it wasn't easy for her to kind of notice that immediately and it was only through the process of talking about the artwork that it seemed to help her make sense of it" (provider participant).

The above themes elucidated practice descriptions about what the art therapist actually did during the session and how he talked to service users about their artworks. This suggests the interview schedule and the use of recorded themes resulted in adequate data that was needed to address the research question.

Feasibility Question Three: Can the Potential for Bias Created by a Moderator's Dual Role in the Focus Group be Controlled for Through External Monitoring?

In order to ascertain whether the potential for bias was created by my adopting this dual role in the research I reviewed existing focus group moderator check lists as per Krueger's (1997) suggestion. Items were drawn from Krueger (1998a) Krueger and Casey (2008), Dubus (1990); Herderson (2011); Greenbaum, 1998). This list was then further refined with my research supervisor based on the particular demand characteristics of the study and resulted in the bias control list (Table 8)

Table 8

Bias control checklist

Introduction section	• Give clear ground rules/purpose statement/full disclosure about microphones? • Declare everyone has consented to be filmed • Asks group members to think about all three facilitators depicted in the same way
Moderator's manner	• Establishes moderators neutrality • Avoid leading respondents (i.e. putting words in their mouth or inappropriate summarise/paraphrases) • Keep self/ego out of the discussion and avoid talking too much • Is non-judgemental • Moderator does not qualify or justify or become defensive about content in the selected time sequence • Listens carefully; synthesises information and feeds it back; probes for clarification; gets people to talk.
Moderator's aims	• Probes without leading; Probes for clarity • Seeks out both cognitive and affective domains; gets participants to tell both how they think and how they feel about a topic. • Moved from general to specific • Conveys "incomplete understanding" effectively • Did not disclose key issues prematurely • Provide linking and logic tracking for respondent and observers
Moderator's handling of group influences	• Permits individual differences of opinion • Obtained member's true feelings about topics • Brings shy or unresponsive group members into the discussion • Encourages conflicting opinion

I then recruited two raters to use the checklist in the feasibility study: A NHS trust research and development lead; and a NHS arts therapies professional lead. This particular skill mix was chosen because it represented the twin needs of an understanding of research methodology and an understanding of art therapy practice. The study design, an outline of the demand characteristics and the bias control checklist were emailed prior to a meeting between myself and the raters. Upon meeting, the raters discussed and reviewed the checklist and were then shown the video clip that the feasibility focus group members had seen. They were then played an audio recording of the focus group. Both raters used the checklist and made notes. They then discussed the validity of the process and this was audio-recorded. At the end of the process the raters gave their opinion about whether the dual role would be feasible for me to undertake in the study.

Both also agreed the checklist was as informed as it could be. An additional search by the research and development lead prior to the meeting had produced an additional focus group checklist by Wong (2008) and guidance from the office of Institutional Research and Assessment (Central Connecticut State University, 2012). However, neither of these checklists revealed any new items relevant to the task.

After reviewing the focus groups both raters rated my focus group competence generally as strong against the criteria of the checklist. They noted particular strengths in following the interview schedule and gaining precise answers to questions, stating synthesis of comments back to the group and striking a good balance between cognitive and affective probing. However, they both strongly rated that the subject of the video edited sequences and the research itself would likely have a high level of invested meaning for me. Both raters identified examples where this may have been problematic. For example both raters noted the need to provide a warm presence in the focus group but suggested my “warmth” sometimes bordered on an overly enthusiastic response, which

may itself be perceived as potentially leading. Phrases used such as “Yes, fantastic” or “really brilliant” might easily communicate that those are the answers that I favoured over others. A rater suggested: “Even saying something helpful is perhaps leading them down a certain way.” However, they agreed a balance needed to be struck between being even in responding and avoiding being robotic or leaving prolonged silences which could also make the group uncomfortable and so might have an effect.

Another of tendency they identified was that in attempting to convey my incomplete understanding I had a tendency to fill in too much with suggestions about what the focus group participant might mean. As rater 1 pointed out: “It’s the attempt to give options as a way of clarification, but by giving options you are in effect leading.” My being close to the subject of the video was seen as problematic in this respect. for example Rater 2 noted that the interview “... brought out really lucid practice description, but then the art therapists in the focus group lapsed into jargon. Maybe you (myself) thought ‘I know what you mean’ but I think you should seek translation on all jargon.” this rater noted the use of the word “containing” as an example of a quasi-technical description which I should have picked up because it has multiple meanings.

One rater identified that there may be a risk that describing the research question too directly (particularly in relation to mentalization) may disclose key issues prematurely and affect the describing of practice in the focus group participants own terms. Instead they suggested it would be better to use the following type of introduction:

> “The present research study is concerned with describing practice. If we can get that we can think about how to improve practice. The problem is its very hard for therapists to describe their own practice so it’s better to have a range of people to describe practice and give their views and descriptions.”

Rater 1 was concerned that this might set up an expectation in therapists in the focus group but rater 2 clarified that “It’s not so much whether therapists can describe therapy, but whether a therapist can describe their own approach. It’s about people going beyond describing their own practice to get a richer description.”

Both raters felt that my closeness to the research and to the question would be problematic for the study. One rater asked if there was anything else that can be done to create distance between myself and the focus groups, such as getting someone to run the focus groups. Both agreed the checklist would be a valuable framework for monitoring quality of a focus group via the audio-recording if this were done. In this respect both felt it did not work well as tick list to mark off key items as they listen to the tape. Rater 2 commented “I think we get more out of it discursively.” However, neither felt a checklist applied after the focus group session would be a strong enough tool to counteract the demand characteristics involved in the dual role. Therefore I concluded that it was not viable to adopt both roles.

Conclusion of Feasibility Study and Implications for Main Study

Adaptations to the art therapy group made to aid filming, such as opening out the group to a horseshoe shape, did not distort the group from treatment as usual to any significant degree. Because the fixed position camera was able to capture the group interaction but did not capture the artworks, the latter needed to be photographed separately. The use of the camera had an effect on participants in the art therapy group but this could be controlled for by the art therapist including the camera in their here and now focus.

Video-edited sequences provided enough information for participants in the focus groups to comment on, but only because the artworks were presented separately. All focus group participants wished to see human interaction on video prior to seeing the AIR.

This did require focus group participants to observe the session twice, which greatly extended the focus group time. Service users were less convinced that the video edited sequence needed to be viewed twice and suggested the use of a still photograph of the artwork. The focus group protocol used provided enough data for focus groups to discuss in relations to the research question. However, the involvement of those who had lived experience of service use implied that the effectiveness of the focus groups was not only dependent on the schedule but also on the skill of the focus group moderator. The evidence from the feasibility study highlighted the existence of potential risk to service users from viewing clinical material if they were not recovered or supported. Clearly service users needed to be in recovery and supported from experienced personnel. Sending the DVD of the selected time sequences beforehand seemed likely to increase this risk because they might be viewed by service users on their own. Conversely, receiving clear questions before the focus group appeared to reduce anxiety and supported focus to the discussion task. It was not possible for me to control for dual role in the research using an external rater or checklist. With these factors in place the main study protocol was assessed as feasible to undertake with the following modifications.

Modification of Research Approach following the Feasibility Study

The video recording approach would be retained and no modifications were made to the use of a fixed position camera. The use of focus groups was retained as a means of data collection but it was agree with my supervisors that it would be too problematic for me to run them and so an external focus group moderator was employed.

The main study extended the “multiple category design” (Krueger, 1997) by moving from two focus group in the feasibility study to four in the main study. In this respect it was recommended that at least three groups were needed for triangulation in this approach (Krueger, 1997). Each focus group would only meet once. Each focus group would

represent a separate population and so more perspectives would be gained. Focus groups have been used in this manner to enrich research data on the assumption that focus group participants improve their feedback by exposure to multiple insights and perspectives from other focus group members (Krueger, 1997).

The focus groups proved to be too long in total for candidate focus group participants to commit to if each art therapy group was shown twice (once as a video edited sequence and secondly as an audio image recording). Therefore the use of a photographic representation of the artwork alongside the video edited sequence. My rationale for this was that this modification was necessary to make the focus groups feasible in terms of time commitment; my primary research focus was to study the actions of the art therapists, rather than to gain views on the artwork; the initial showing of the video edited sequence in the feasibility study had produced a great deal of relevant discussion.

Having outlined the justification for modifications to the methods employed, I now wish to present a detailed description of the procedures used in the main study and the results they produced.

Chapter Six: Methodology for Main Study

Procedures

I begin by outlining the ethical procedures undertaken prior to the study and then outline the participant recruitment processes. The present study utilised two types of participants: firstly, the art therapy clinicians who submitted video-edited sequences of their art therapy practice and secondly, those who attended four focus groups which observed and discussed those video-edited sequences. I describe the recruitment for each separately. To give some indication of the data the focus groups observed I both include line drawing representations of the layout of the group art therapy sessions as captured on video and digital photographic representations of the images discussed in the art therapy groups. Then, because grounded theory approaches vary, I outline the coding procedure used within a social constructionist paradigm in some detail as part of the data analysis section. I describe how social constructionist epistemology informed research decisions within the present study. This included the choice of a pre-study literature review, observational methodology and the constitution of focus groups. Because grounded theory was the analytic method used in the main study, particular space is given to describing its employment within a social constructionist framework. Epistemological concerns have been of such importance in grounded theory that they created a schism between the originators of the method. By outlining the principles underlying that schism, I hope to clarify my position as a researcher within the grounded theory approach. The chapter concludes by reflecting on the scope of theory that these research decisions may allow me to claim.

Ethical approval. Direct observation of clinical practice by focus groups would be highly disruptive and unethical. For this reason, audio-video recordings were used to

capture clinical practice. This is a common method of viewing sensitive clinical practice because it is less intrusive (Alpert, 1996).

Formal ethical approval for the use of video recording and focus groups was gained via the National Research Ethics Service (Appendix F). The study involved complex data protection issues with vulnerable adults both within the art therapy groups being videoed and within the Emergence focus group. Therefore written informed consent was required from art therapy group participants, treating art therapists, and focus group participants (Appendices G, H, I). Because the Emergence focus group was formed of former-service users within a third sector organisation, additional assurance was sought from the ethics committee regarding Emergence's insurance status, capacity to ensure confidentiality and for their provision of support to focus group participants should they be unsettled viewing clinical material (Appendix F). In addition to this it was stipulated that the focus group conductor should have both focus group and clinical skills relevant to people with a diagnosis of borderline personality disorder, should any Emergence participant become distressed by viewing clinical material. Ethical approval was granted on receipt of assurance for the above. Following ethical approval, local research and development approval was gained from the NHS sites providing recordings from art therapy groups. This included my visiting research sites to negotiate the data protection and ethical process the clinical teams would need to undertake.

Participants: Gaining video edited sequences of art therapy groups. The art therapist group facilitators were recruited from the British Association of Art Therapists personality disorder special interest group (BAAT-PDSIG). Special interest groups are the association's way of organising members around clinical specialism to develop practice and research. The BAAT-PDSIG was used to sample from because it was the best means of convening an homogenous sample of comparable practice video recordings that

addressed the research question. The criteria for inclusion was that in addition to possessing a Health and Care Professions Council recognised qualification in art therapy and membership of BAAT-PDSIG, they should have received training in the MBT model from the Anna Freud Centre, London. All art therapist needed to deliver art therapy within programmes involved operated the MBT approach delivered on concomitant mode, meaning they had both group art therapy and individual verbal therapy from another therapist. This group of treating art therapist, which included me, also formed the last focus group.

This recruitment strategy resulted in the following data for analysis by focus groups. The art therapy groups sampled were taken within three separate UK National Health Service trusts which provided mental health secondary care. The threshold for secondary care included users having had severe and enduring mental health conditions requiring specialist treatment beyond the means the primary care provided by their general practitioner. In all services, a number of service users also had received additional diagnosis, such as post-traumatic stress disorder or recurrent depression alongside that of those who received a diagnosis of borderline personality disorder. NICE guidelines state that in those cases, the features of borderline personality disorder should be addressed first. All had undertaken a psycho-educational programme prior to joining their programmes.

All treating art therapists who agreed to submit video edited sequences received an information sheet about what was required (Appendix H) this described how to select a video edited sequence as follows.

> "I would like you to choose a 10 – 15 minute part of a group where you feel you were talking to the patient in the group about their art work (the triangular

relationship) in a therapeutic way. We have very little theory to guide us as art therapists on this so I would like you to use your own judgement."

I met with the treating art therapists to agree a shared clinical approach to the introduction of video into art therapy. This did not involve me prescribing any details of what might constitute talking to service users in a therapeutic way because I was interested in their autonomous choice of video edited sequences within that description. The treating art therapists decided that because the MBT technique focused on mentalizing whatever occurred in the here and now, we agreed that the video should form part of that here and now clinical focus. We agreed to talk openly about the video, just as we would approach mentalizing any other phenomena in the here and now of the group. The aim of this was to keep the treating art therapists approach stable. On this basis treating art therapists sought consent to introduce video cameras into their art therapy sessions for a period of at least three months. The treating art therapist then independently selected video edited sequences from their own video recorded data. Video edited sequences were transferred securely to me using the data protection guidance I issued with the information sheet (Appendix H).

Three sample video edited sequences. All of the art therapy groups featured took place in dedicated art therapy studios and all used a turn taking approach to group work. Each of the audio-video recorded sequences had a small number of characteristics such as room layout, positioning of service user and therapists, which varied amongst settings. A number of service users only consented to be videoed if their faces could not be viewed directly. These structural features were referred to by the focus groups and are so presented below in diagrammatic form to preserve anonymity (Figures 16, 19 & 21) with the images discussed by those groups (Figures 17,18, 20 & 22).

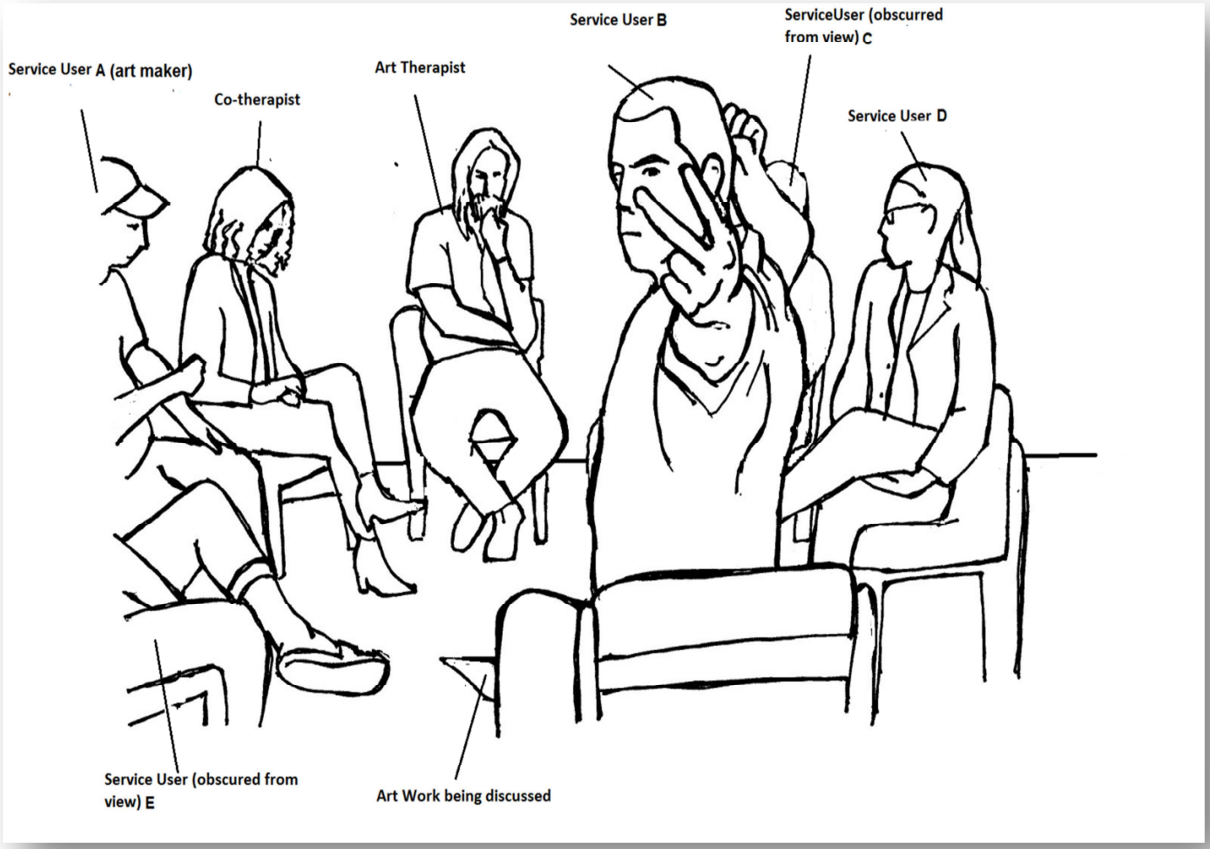

Figure 16: Group one had five service users of mixed gender, a male art therapist and a female non-art therapist co-therapist. At one point a service user turned to the camera to make an obscene gesture. Sequence lasts 16 minutes 03 seconds

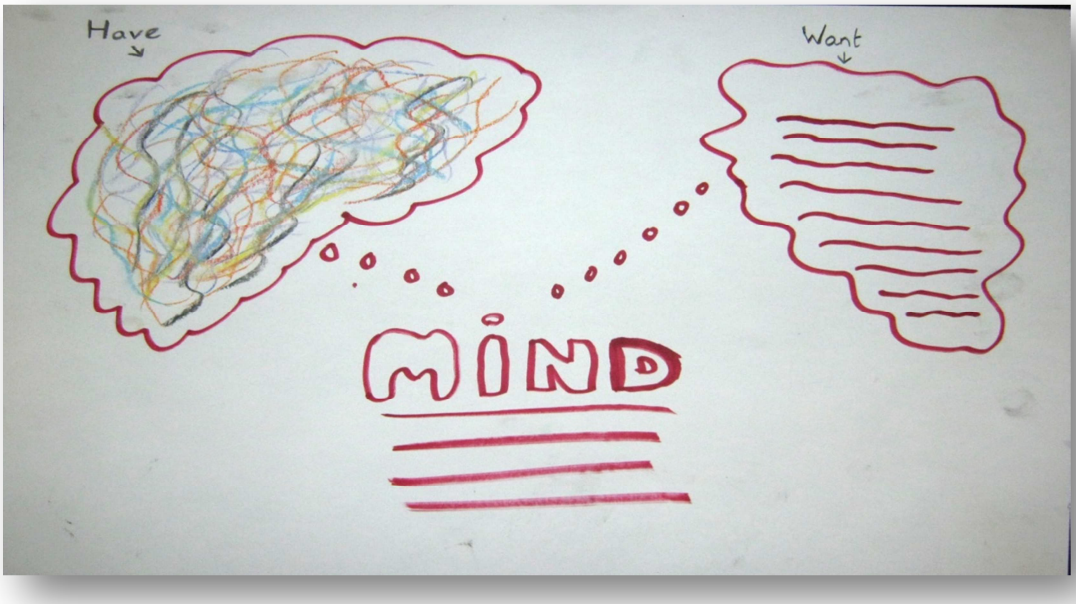

Figure 17. Service user A artwork who was the main focus of the group discussion.

Figure 18: Service user B's artwork, referenced in discussion in group one

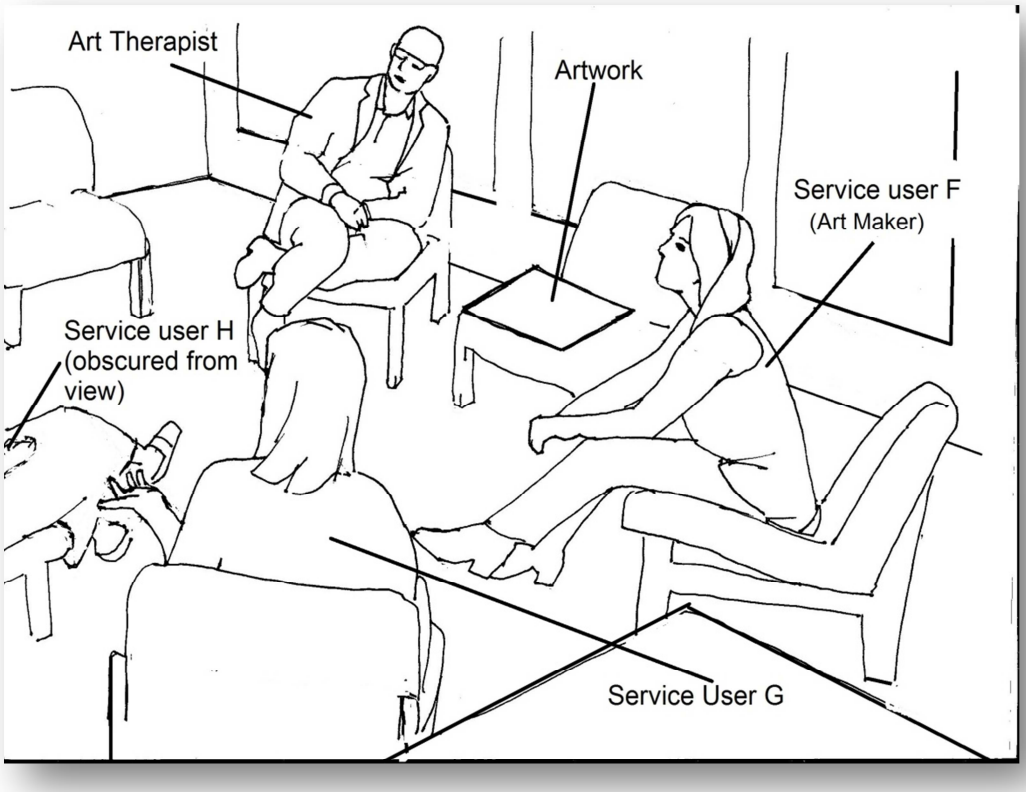

Figure 19: Group two had three service users, all women, and one male art therapist. Sequence lasts 14 minute and 55 seconds

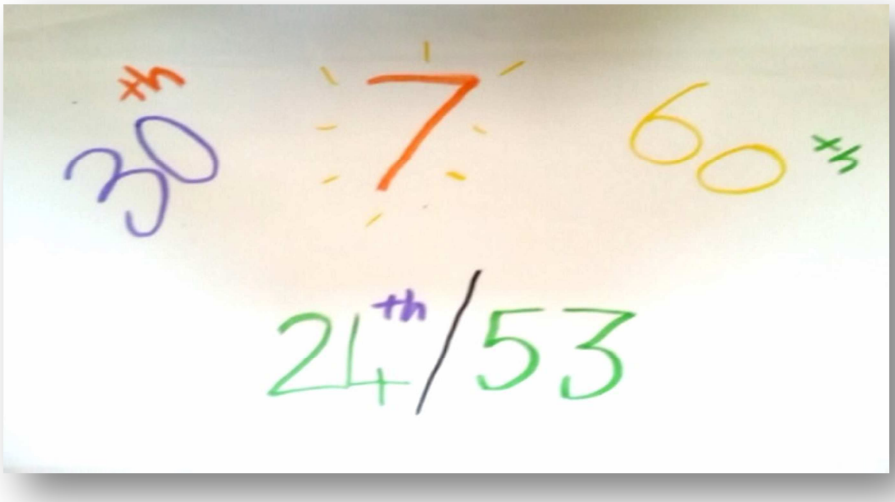

Figure 20. Service user F's for discussion in group two

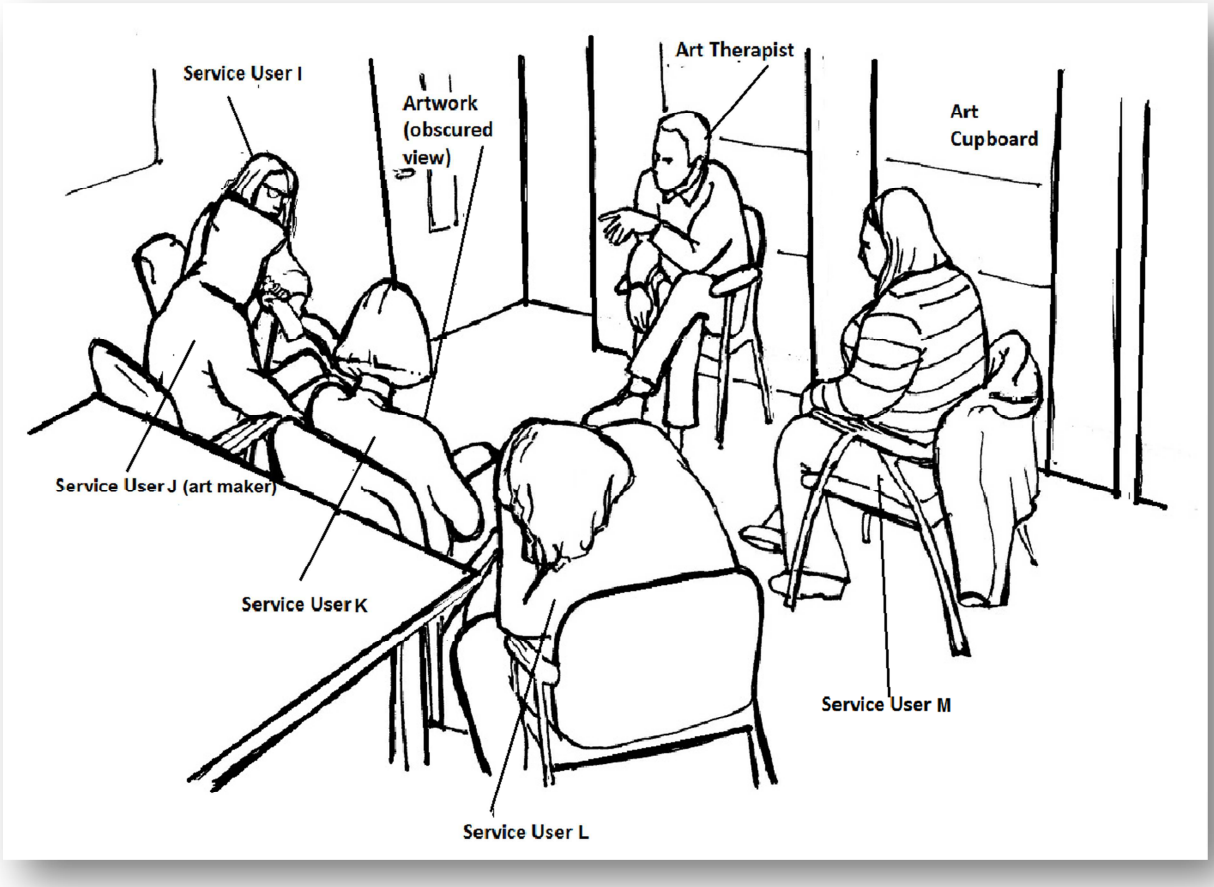

Figure 21. Five female service users and one male therapist sitting in a circle. The video edited sequence lasted 19 minutes and 30 seconds.

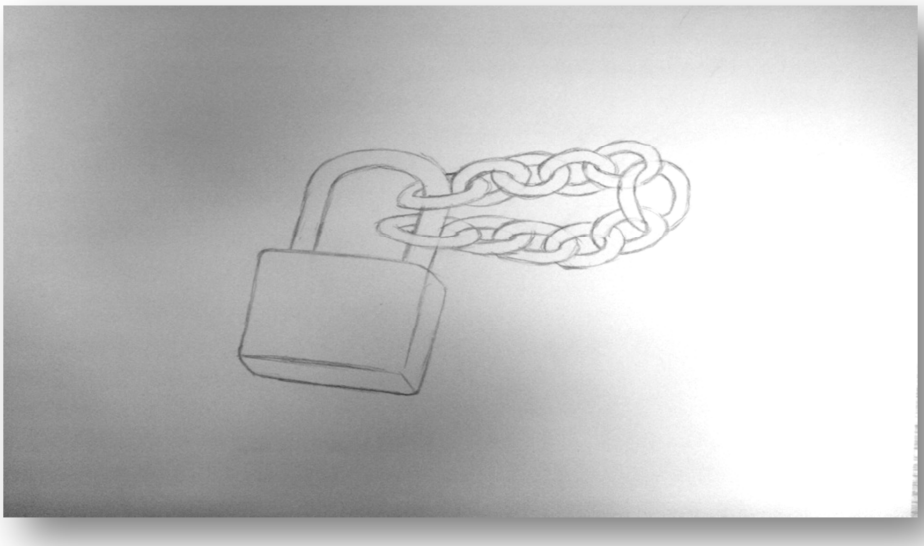

Figure 22. Service user J's artwork.

Participants: Recruitment for focus groups. The same concern for homogeneity as had been involved in the recruitment art therapists to submit video recordings was applied to the four focus groups. This was as follows:

1. Service users were recruited from Emergence researchers, as experts by experience in service use. I had been involved with the precursor organisation that formed Emergence (Personality Plus) since 2008. I initially contacted Emergence for the present study by attending its open day and making contact with its lead researcher. From this point the research protocol was formally shared with Emergence and a sum of £700.00 agreed for the forming a focus group including members who had lived experience of art therapy treatment.
2. Mixed non-art therapist psychological therapy practitioners who worked in an MBT model with people who have a diagnosis of borderline personality disorder were recruited via the chair of the Oxleas NHS Foundation Trust Practice Research Network.
3. Art Therapists who work with people who have a diagnosis of borderline personality disorder were recruited via the chair of the BAAT-PDSIG who tabled the research for discussion at a meeting on 20th May 2011. Art therapists in this category did not necessarily work with a mentalization model. No participants in the focus groups were in a position of power in relation to any other. None had submitted video edited sequences.
4. Art therapists who had submitted video edited sequences, including myself.

Focus Group Procedure

Focus groups were purposefully conducted in a sequence starting with Emergence, then psychological therapists practising in the MBT model and ending with art therapists (Figure 23).

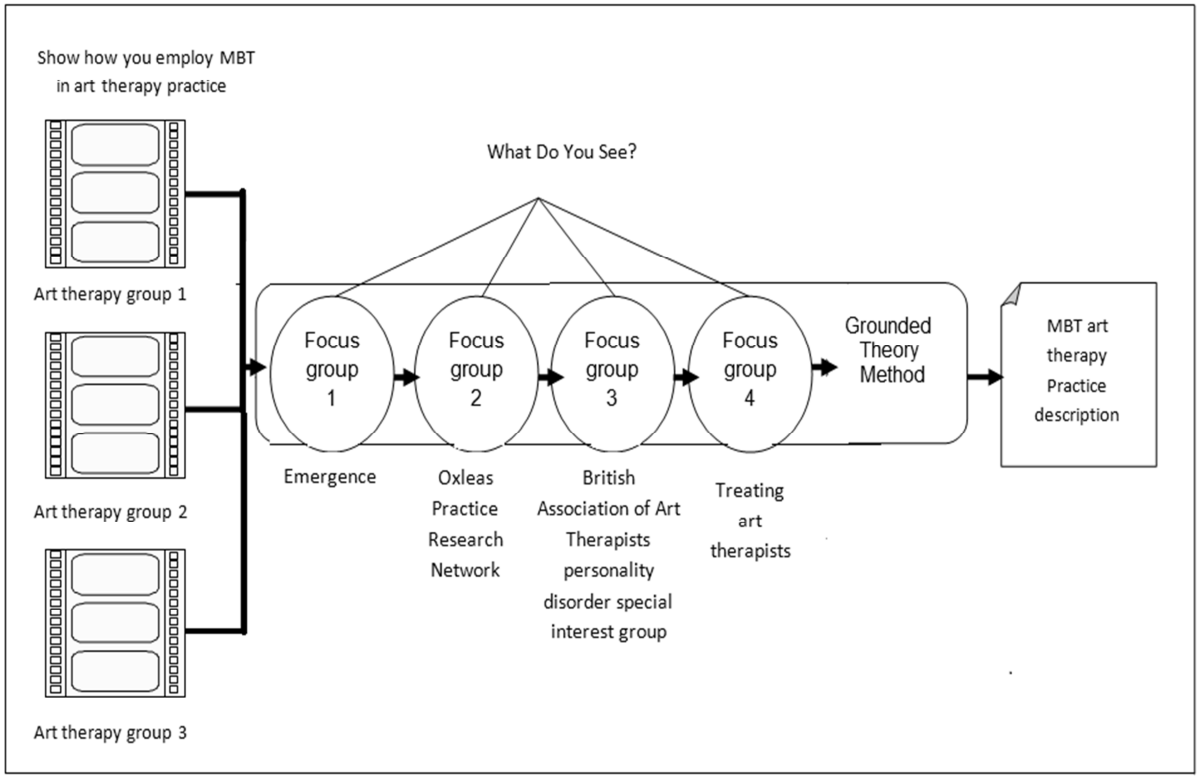

Figure 23. Multi-category focus group design.

My rationale for the sequential order of focus groups was that it reversed the therapist-centric norms of art therapy theory building, as identified in the literature review, which most often started with the art therapist's view and added in the view of other psychological therapists and service users. Focus groups were internally homogenous but externally heterogeneous to each other. This constituted a form of quota sampling, where I explicitly aimed to gain four distinct perspectives. I discuss the implication of this for the analysis after I have described the grounded theory approach used (below).

A focus group moderator was employed who met the criteria laid down by the ethics committee. This involved having both group skills and clinical experience in working with

people with personality disorder diagnosis. The focus group moderator and I discussed the aims of the study in relation to the semi-structured interview schedule that would be used to start within the first focus group (Table 9). Following its use in the feasibility study, the interview schedule was modified to include a clearer introduction which emphasised the relevance of seeking observation based description of art therapy. Questions also more explicitly asked for action of the art therapists and the perceived consequences of those actions.

Table 9

Interview schedule

Introduction for focus groups: Art therapists can find it hard to describe art therapy. Sometimes others can describe phenomena by looking at it from the "outside".
Focus The study is only looking at one aspect of art therapy, that is: how art therapists talk with people about their artwork. *It is not looking at how the artwork is made (use of materials, how the art therapist helps person make art, the art therapy environment).*
Background All groups shown are part of Mentalization-based treatment programmes which include an art therapy group and verbal individual session run concurrently. Every participant has had psycho-education about the borderline personality disorder diagnosis and MBT treatment. The art therapists selected a short clip where they felt therapy was happening. We will use 3 focus groups: Emergence; MBT psychological therapists and art therapists from the BAAT personality disorder special interest group.
We would like you to help these art therapists by putting the practice you see into plain English, as if you were describing it to a non-art therapist reader of the research study. The aim is not to decide if the practice is effective (that would be an RCT study), but to describe what is happening and the try to explain why it might be important to the condition being treated.
Please take notes if that helps you, noting time sequence. We can always go back to a specified point on the audio-video recorded sequence.

Aim	Question
What we are asking focus group participants to do	• The therapists set up this phenomenon so <u>everything and anything</u> you notice happening in it is important. • We really value understanding why, from your experience, you rate that observation as important.
General observations of art therapy	• What was your first impression of the art therapy group? • Is this what you thought discussion in art therapy would look like? • How would you describe this art therapy group to the non-art therapist reader of this study?
Observations of therapist action	• What would you say the art therapist is doing? • What do you feel he is trying to achieve?
Observations of participant's experience	• What do you think is happening for participants? • Are different things happening for artist and viewers of the artworks?
Observations of therapeutic change	• Do you feel you can see any therapeutic change? • Is it the same for viewers and artists? • How would you describe the beneficial elements? • Any other thoughts?

I asked the focus group moderator to pay special attention throughout all groups to differentiating focus group member's speculation from observation. Where it was unclear if focus group members were referring to an action observed or to one remembered from

lived experience or speculation, the focus group moderator would ask clarifying questions. Focus group members could then clarify if it was their observation, previous experience or other knowledge. For example, the following transcript showed how questions worked to differentiate observation from recall or speculation:

> Focus group participant D: "It raises issues for me about like, a guy facilitating what looks like an all women group. I'm making a bit of an assumption here ... but I wonder how that fed into the group dynamic"
>
> Focus group leader: "You were talking about gender differences and dynamics; did you see anything in that clip that would have made you think they were influencing the course of the therapy?"

The following occurred four minutes after the above question had been posed by the focus group leader:

> Focus group participant D: "I suppose, you asked directly about the gender stuff I raised. It was just in my mind as how does that guy relate to what they are talking about?"
>
> Focus group leader: "How did people see him relating to that?"
>
> Focus group participant A: "He didn't, he didn't ..."
>
> Focus group participant D "I didn't get a sense that he was relating to that. They seemed close and shared stuff and he just didn't"

Use of interview schedule between focus groups, two, three and four. On completion of each focus group I produced a verbatim transcript of the focus group discussion. I added emphasis to verbalizations, such as the raising of voices or silences were annotated within that transcript as recommended by Krueger (1997). I then re-read each transcript and began open coding. From this I generated theoretical memos which were used as the basis for additional questions by the focus group moderator. In line with

Krueger's (1997) multi-category approach, if the items my theoretical memo identified did not arise from the semi-structured interview schedule, the focus group moderator would describe the point after the interview questions had been exhausted in order to give subsequent focus groups the opportunity to consider it. Because this was a stepwise analytic process, where questions were developed based on analysis of specific results, I detail the precise theoretical sampling questions used as part of the results chapter.

The focus group moderator conducted four focus groups following the same format using the semi-structured interview schedule as a starting point. The focus groups began with the video edited sequences of art therapy group interaction being shown using a data projector and sound amplifier. Alongside this still representations of the artwork discussed was simultaneously presented in photographic form (8 x 10 inch reproductions) for each focus participant to hold. All focus group discussion was audio-recorded using a condenser Zoom H2 microphone to capture 360 degree sound.

Epistemological determined decisions in the present study. The view of art therapy literature through a social constructionist lens helped to identify some important gaps in knowledge. Social constructionism challenges the premise that any one person, by virtue of a clinical training can hold the truth about such a complex social interaction as an art therapy group. Moreover, by starting with such a dominant psychoanalytic theory base, it was possible that art therapists favoured those descriptions of their practice which best fitted within it. Therefore I was interested in whether taking the observation of practice, rather than theory, as a starting point might yield new insights. In regard to this, a social constructionist epistemology forced questions about who those observers should be. The literature review revealed that only Pounsett et al (2006) involved non-art therapy observers, namely psychologists, in observational research into art therapy. Whilst evidence was accruing to the value that service users offered observational methods (Bedi,

Davis & Williams, 2005), none had ever been reported contributing to such research in art therapy. Social constructionist epistemology was therefore crucial in identifying a significant gap in knowledge: what would a range of observers of art therapy practice contribute to theory? In the present study I reasoned that this should include non-art therapist professionals who treat people with a diagnosis of borderline personality disorder, but also service users who have lived experience of the condition too.

Having conceived of a means of widening the viewers within an observational approach I needed an analytic methodology that would be congruent with using their observations, rather than extant art therapy theory, as a starting point. A number of analytic options were considered. Chief amongst these were thematic analysis and content analysis. Thematic analysis is a commonly used form of analysis which identifies meaningful patterns as themes within data. Braun and Clarke's (2006) model of thematic analysis involved six phases: familiarization with data; generating initial codes; searching for themes among codes; reviewing themes; defining and naming themes; and producing a summary for the final report. However, thematic analysis has been criticised for producing only summaries of data which can lead to the de-contextualizing of the original material (Kvale, 2007). Thematic analysis had been also criticised for providing limited interpretive power, particularly if analysis excluded an explicit theoretical framework (Bryman, 2008). Content analysis shared many characteristics of thematic analysis in that researchers quantify and analyse the presence, meanings, and relationships of words and concepts within texts or other cultural artifacts. However, because content analysis demands a set technique to follow, using explicit coding schemes, it has been claimed that it makes replications and follow-up studies more feasible than thematic analysis and has the potential to reveal deeper patterns hidden within data (Krippendorff, 2004). At its most basic, content analysis is a statistical exercise that involves categorizing a specific aspect

of behaviour as identified by codes and counting the number of times such codes occur (Neuendorff, 2002). However, the predetermined and highly schematic nature of the content analysis method has been described as being insensitive to its own data, particularly with regards to building theory about what conditions drive behaviour (Charmaz, 2006).

Grounded theory is a qualitative form of analysis, which has six common features:

1. simultaneous data collection and analysis,
2. pursuit of emergent themes through early analysis,
3. discovery of basic social processes in data,
4. an inductive construction of abstract categories that explain and synthesize these processes
5. sampling to refine these processes through comparison, and
6. integration of categories into a theoretical framework (p. 313)

My rationale for using grounded theory was that it was an established method of qualitative analysis method which aims to generate theories of action within social phenomenon (such as in an art therapy group). It had been little used in art therapy and so might reveal new insights into the practice. The original grounded theory model began as a criticism of the "over emphasis in current sociology on the verification of theory and resultant de-emphasis on the prior step of discovering what concepts and hypotheses are relevant for the area that one wishes to research" (Glaser & Strauss, 1967, p 1). My view was that this criticism was a good match of the present state of art therapy theory building, which I argued was similarly at risk of reifying its own theory by constantly referencing, and perhaps limiting, all descriptions of practice to those that fit existing literature. In

terms of building descriptions of practice, grounded theory had shown utility in generating theory from observation, involving diverse populations, from its start.

Glaser and Strauss (1967) made no epistemological claim for grounded theory and as it has been applied over time its procedures and underlying epistemology has diversified. Madill, Jordan and Shirley (2000) demonstrated that grounded theory does not inherently exist within a given epistemology by generating and contrasting positivist and constructionist codes from a single data source. Their study found the grounded theory method uncovered basic structures of both positivist and constructionist results in the same data. It was no longer possible to describe grounded theory as a unitary method exiting within a single epistemology. Leading practitioners from various sides of the epistemological debates agree the strongest studies detail both the approach the study's authors have taken and their reasons doing so (Charmaz, 2006). Therefore I now wish to outline the grounded theory approach taken within a social constructionist epistemology.

Social Constructionism and Grounded Theory

Charmaz characterised the social constructionist contribution to the original model of grounded theory as being where Glaser (1978) asks: "What are the basic social processes in a phenomenon?" the social constructionist grounded theory adds: "Basic to whom?" (Charmaz, 2006, p. 14). Social constructionist epistemology has increasingly been used in grounded theory studies within the sphere of health research. Social constructivism has often revealed and addressed the power differentials involved in research between those in need of healthcare and those providing healthcare services (Hoare, Mills, & Francis 2013; McCreadie & Payne, 2009; McCreadie & Wiggins, 2009). It seemed reasonable to assume that similar power differentials operated when an art therapist interact with service users in clinical practice. A social constructionist approach to researching art therapy might likewise add new perspectives to existing theory.

A social constructionist approach has profound implications for the procedures undertaken within a grounded theory method. In fact, such epistemological concerns were at the heart of the famous Glaser-Strauss schism and subsequent contested history of grounded theory. This split initially revealed itself over a specific matter of coding method, but the relationship between epistemology and method was so fundamental in grounded theory that it has been claimed that to understand the Glaser-Strauss schism is to understand grounded theory itself (Urquhart, 2013). To summarise, Strauss and Corbin (1990) described the need to follow four prescriptive coding steps of; open; axial; selective; and coding for process, cautioning that not following these analytic steps would lead to lack of density and precision. Glaser (1992) described Strauss and Corbin's approach as proscriptive, forcing data through a conditional matrix and as the antithesis of grounded theory which he viewed as a method which makes the researcher as an individual responsive to the data. In this sense the researcher is an active participant was the driver in constructing their theory (Glaserian), rather than the method as the driver which if followed rigorously might reveal a reality independent of the researcher's analytic decisions (Straussian). Glaser's (1978) concept of theoretical sampling captured the active stance of the researcher as a human being who makes decisions by using their own analysis of the data to decide where they will sample from next (Urquhart, 2013). Notably, Strauss and Corbin (1998) did later soften their opposition to Glaser's criticism by stating their own "... paradigm is nothing more than a perspective taken towards the data" (p. 128) and not a rule. Other Glaserian proponents argued that grounded theory's strength was that its guidelines offered a set of principles and heuristic devices and not a set of formulaic rules which thereby facilitated greater researcher sensitivity to the phenomenon being studied (Charmaz & Henwood, 2008).

Charmaz (2006) locates the Glaserian position closer to social constructionism because the analysis and theoretical sampling is explicitly driven by person of the researcher. Star (2007) suggested his approach foregrounded the researcher as a person having both cognitive and emotional responses to the subject, because: “Coding sets up a relationship with your data” (p. 80). This position raises the question about the grounded theory researcher’s relationship to prior knowledge, either in the form of a literature review or in experience within the subject under study. In their original conception of grounded theory, Glaser and Strauss (1967) assumed a binary position towards distinguishing inductive theorization directly from data and using data to reify grand theory. Their suggestion was that prior knowledge gained either through literature reviews or through lived experience could contaminate the grounded theory researcher's observations. Later grounded theory practitioners framed Glaser and Strauss’ original attempt to claim that the researcher can be *tabula rasa* as an anxiety to gain objective credibility in a (then) positivistic research culture (Charmaz & Mitchell, 1996; Dey, 1999). Social constructionism challenged the idea that the researcher can, or needs to be, without prior knowledge to develop a valid theory of social phenomena. Thomas and James (2006) summarised the originators’ claims of objectivity as the main criticism levelled against grounded theory as a research method.

Glaser’s (1978) own work on “theoretical sensitivity” retrospectively acknowledged a shift from that binary position to prior knowledge, in stating: “We are not passive recipients into which data is poured.” (p 15). Theoretical sensitivity aims to use explicit reflection by the researcher on their experience and attitudes as part of the analytic process. This has been described in the often quoted phrase: “We should not confuse an open mind with an empty head.” (Dey, 2007, p 176). Later practitioners went further and claimed that awareness of extant theory could benefit grounded theory studies: “Amongst

many grounded theorists it is generally accepted that a pre-study literature review has to be conducted to find the research problem." (Nathaniel, 2006, p. 40). Other see a literature review as essential: "A literature review gives me current parameters of the conversation that I hope to enter" (Lempert, 2007, p 254). In health research, nurse practitioners used their knowledge and working experience as theoretical sensitivity in shaping their grounded theory approach (Hoare, Mills, Francis, 2013).

This does not imply that social constructionism abandons all concern for data contamination. Charmaz (2006) recommended that the term "theoretical agnosticism" (Henwood & Pidgeon, 2003, p. 148) rather than "theoretical sensitivity", more accurately described the position of the researcher in the relationship between prior knowledge and openness to new phenomena. Theoretical agnosticism described a reflexive stance where textbooks are read but considered as problematic: "The real danger of prior knowledge in grounded theory is not that it will contaminate a researcher's perspective but rather that it will force the researcher into testing hypotheses, either overtly or unconsciously, rather than directly observing." (Suddaby, 2006, p. 635).

Cutcliffe (2000) described the need for grounded theorists to: "(...) acknowledge his/her prior knowledge and tacit knowledge, to bring it to the open, to discuss how it has affected theory development" (p. 1479). Theory derived from the research process and scholarship should be subject to comparison to experience as it is lived by the researcher. Charmaz (1990) locates this process within the overall interactive relationship between theory and data throughout the life of the grounded theory study: "Once the researcher has developed a fresh set of categories he or she can compare them with concepts in the literature and begin to place his or her study within it" (p. 1163).

My approach to grounded theory was to acknowledge that I was already in the field and could not possibly claim a *tabula rasa* mentality to art therapy. I argued that this

foreknowledge had in fact aided the focus of my grounded theory study and a social constructionist epistemology helped me to consider how to make this explicit in the research diary. Performing a literature review was also important in this respect because it forced me to take a more systematic approach to a body of literature that I both knew and had been written by people I knew. I was then better able to separate out what the literature actually said and my memories of the people who had written it. These two had in fact become a little blurred prior to the literature review. With this consciously in my mind, I was then also better able to differentiate what viewers had described in the focus groups from the literature and the interactions I had had with the authors in the world of art therapy. Clearer awareness improved my ability to take a reflexive approach to support theoretical agnosticism. I used the research diary to log decisions and preconceptions, discussions with supervisors and peers in order to reflect on their effect on the research.

A social constructionist approach to grounded theory has implications not only for the role of the researcher but also for the scope of theory that can be produced. I should now like to discuss this.

The scope of a grounded theory from a social constructionist perspective. Theory derived grounded theory is formed by a process of inductive reasoning, where conclusions are based on premises. Grounded theory studies claim validity based on being able to point to many instances in the data for their theory. This claim has led to controversy about the scope, or generalisability of theory that inductive methods, including grounded theory, can produce. Urquhart describes a sobering experience of being told by a quantitative researcher that because it derives from particular contexts, qualitative research itself could be dismissed as producing low level theory equivalent to no more than "a nice story" (Urquhart, 2013, p. 153).

Dey (1999) argued the roots of controversy about generalisability were apparent from the start when Glaser and Strauss (1967), in his view unsuccessfully, attempted to distinguish between substantive theory (study of phenomena in one context) and formal theory (study of phenomena under many types of situations). Dey observed that although Glaser and Strauss admitted that both formal and substantive theorising used the same method, they implied substantive theorisation was in some way an incomplete version of formal theory. Again, Dey positioned their implication in its time, arguing that the social sciences in the 1960s tended to assume a naive idea that science only sought to deduce universal laws which were applicable in all contexts and undervalued the important role of scientific theory in explaining particular phenomena. At heart, Dey's critique centred on the issue of generalisability in research, that is how a phenomenon indentified and described in a case applied beyond its own time and place. Walton (1992) suggested two opposing definitions of "case" tend to operate in this respect. The first was nomothetic where a case offered an example of a principle which operates in a wider context of other cases. The second ("encased") was idiosyncratic and was a discrete phenomenon with no wider reference. Dey (1999) argued that this accepted distinction represented a false dichotomy in social sciences because the particular and its context were always mutually implicated: "Indeed the social construction of events undermines any claim that idiographic theorising can focus on any particular event in isolation" (p. 218). As an example he cited the case of Native Americans disputing that they were discovered by Europeans: for the latter their discovery was a case with a defined beginning, for the former this was merely a point in their long history. Social constructionism suggests "Theory provides interpretative frames from which to view realities" (Alasuutari, 1996, p. 115) and so is strongest when those actors who hold those perspectives are foregrounded in the research process.

Epistemological assumptions about generalisability have direct implications for the procedural methods, particularly the sampling strategy, in grounded theory. Generalization poses the question: 'When is enough data, enough?' Dey criticised Glaser and Strauss' (1967) notion of theoretical saturation in this respect which he views as "an unfortunate metaphor" (Dey, 1999, p. 257). He saw the term saturation as aiming to imply a (positivistic) completeness of sampling where no new categories are suggested. He suggested Glaser and Strauss wished to confer the status of positivistic outcomes by the use of the word saturation, as in cloth so wet that it can absorb no more water. He argued this does not reflect the reality of a complex social world where saturation can never be guaranteed because it is impossible to say if the next sample after data collection would be the one to indicate a new category. Others similarly argued that the concept of theoretical saturation risked creating "a teleological closed system" (Charmaz, 2006, p. 114). In health research there may be limited access to data because of the ethical sensitivity involved in viewing highly personal and confidential experience. This was certainly the case in the present study where *in vivo* art therapy was shown to a range of viewers including service user researchers. In such cases grounded theorist researchers have recommended the researcher returns to the data rather than the field to pursue patterns of social interaction that may well be hidden on first reading of the data set (Bradley, 2010; Timmerton & Tavory, 2007).

Dey suggested the Glaserian view of theoretical saturation (Glaser, 2001) was better described in his text than in his title, in that it was theoretical saturation of the "properties of the pattern within the code" and not for the range of codes that was aimed for (Dey, 1999, p. 191). Instead, Dey offered the alternative term "theoretical sufficiency", now widely cited in grounded theory studies. This term sought to clarify that the aim was to

collect enough data to sufficiently describe the action within the code and resulting categories.

Dey (1999) proposed that the notion of theoretical sufficiency might mitigate the false dichotomy between nomothetic and ideographic data and formal and substantive theories. He recommended three uses of case comparison for developing generalisable theory:

1. Substantive generalisations which compare a case with previous cases,
2. Analytic generalisations which compare the case with existing theory,
3. Innovative generalisations, reformation of received ideas which can develop new theories or questions (p. 218).

Dey (1999) admitted that the validity of the theory depends on the skill of the researcher but "(...) at best [grounded theory] offers a way of producing generalisations through comparisons while retaining a holistic sense of causal complexity." Equally he admitted that "(...) at worst it loses both intensive theorising depth and rigour of comparative enquiry" (p. 230).

Theory produced by grounded theory has been scaled up through mixed methodology approaches. Urquhart (2013) also notes that because grounded theory is a flexible method it can generate theory for specific purposes as a part of a wider theory building strategy. Within the health sphere it has often been used as a form of data analysis for such purposes as questionnaire construction. Urquhart, Lehmann and Myers (2010) note that in contrast to the original Glaser and Strauss (1967) model's antipathy to literature reviews, later grounded theory have successfully scaled their theories through the linking of findings back to the pre-study literature review. This was the approach taken in the present study where a pre-study literature review was revised as part of the post grounded theory results discussion section. The aim of that discussion was to examine

what the grounded theory method revealed that was new, supportive or contradictory of extant art therapy theory.

Summary

Charmaz offers a clear description of the approach the present study attempts: “To the best of their ability the social constructionist enters the phenomenon, gains multiple views on it and locates it in a web of connections and constraints” (Charmaz, 2006, p. 187). A grounded theory approach within the social constructionist epistemology was assumed to be the most direct way of counteracting traditional art therapist centric theory building methodologies. This widened the range of people who contributed data through the video-edited sequences and took part in the focus groups. It explicitly positioned me as the analyst of the data they produced and in this respect made the research diary essential both as a means of defining the first person “I” used throughout the study and as a reflexive tool. The pre-study literature review then made explicit my knowledge of a field I am deeply involved with. That literature would then be used as a means of scaling up the grounded theory produced by the study.

Grounded Theory Data Analysis

In common with a number of qualitative methodologies, grounded theory utilises coding as a basic process: “Coding is a procedure that disaggregates the data, breaks it down into manageable segments and identifies or names those segments” (Schwandt, 1997, p. 16). However grounded theory coding is distinct in moving iteratively, from the descriptive to the analytical level, with the aim of pursuing a theory of social pattern that may be latent in the data. Grounded theory constantly compares all levels of abstraction as a form of abductive inference, described by Charmaz as considering all possible theoretical explanations for the data, then forming hypotheses which are then used to re-check that data in order to pursue the most plausible explanation (Charmaz, 2006). Codes

build constructs as the basis of hypothesis, but the crucial step in grounded theory is the naming of relationships between those constructs and using theoretical sampling to gather more data on their properties. Such relationships are not intended to be causal as in quantitative research, but are described by many authors as aiming to explain how A is part of B, or how A influenced B (Urquhart, 2013).

Within grounded theory there are variations in the coding approach used by proponents of particular methods. I chose the method described by Charmaz (2006) because it was so explicitly based in social constructionism. Before describing the exact coding process used, it is necessary to outline how data were managed because transcription of the four, three hour, focus groups involving sixteen participants had resulted in 57,446 words of text. Due to the large size of this data set, QSR-NVivo version nine software was used for the purposes of developing codes. When computer software was introduced to qualitative research a number of critics feared it would lead to rigid automated processing of data by researchers who did not fully understand the methodology underneath the technology (Kelle, 1995). However, features of QSR-NVivo had increasingly been used for grounded theory studies and proponents claimed it increased the transparency of data processing (Hutchinson, Johnson & Breckon, 2010). QSR produced video learning resources for grounded theory which I used to familiarise himself with the salient features. The NVivo free nodes function was used to create open codes from text. The parent node function was used to create focused codes. Folders were used for grouping constructs. NVivo coding stripe and highlight system was frequently used as part of constant comparison to provide an over view of coding density. In addition to using the software programme, text was sometimes manually analysed and diagrammed to explore theoretical relationships between codes.

I coded transcripts via an iterative process of open, focused and theoretical coding, followed by categorisation as described by Charmaz (2006) and the procedure of this is now described. It is important to stress that the terms open codes, focused codes, theoretical codes, conceptual categories and core categories refer to levels of abstraction and not to procedural steps. The process of constant comparison occurs at all stages and between all levels of abstraction (Figure 24).

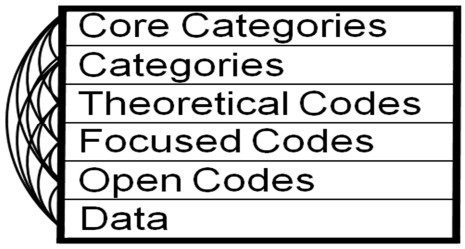

Figure 24. Curved lines show the matrix of constant comparison between all levels of abstraction

Constant comparison involved continuously asking: "To what category does this incident or property relate?" (Urquhart, 2013, p. 23). All levels of abstraction were subjected to scrutiny, theoretical sampling and potential revision throughout. Some open codes even became conceptual categories where they represented a larger theoretical concept. This was applied as an iterative process of theoretical memo writing, coding and theoretical sampling until theoretical sufficiency was achieved.

Open coding. Coding of segments of text was initially done speedily with gerunds (a form of verb functioning as a noun usually achieved by adding "ing" (as in from play to playing) to code data as action: "This method curbs our tendency to make conceptual leaps or to adopt extant theories before we have done the analytic work" (Charmaz, 2006 p. 48). I found that coding for action also supported the social constructionist epistemology because coding for *action* also demands that the *actor* is considered. For example, at one point a focus group participant said that they wondered if looking at a picture instead of

the therapist in art therapy lost the sense of embodiment between the people involved. This could have been coded as “image viewing looses embodiment” but when coded as “observer wondering if image viewing looses embodiment” the emphasis is placed on the actor’s (observer) action (wondering). This made the latent idea of the code more provisional, reduced the risk of prematurely reifying it as a concept and more accurately differentiated direct observation from speculation as the action involved. This approach was helpful at this early stage of coding in keeping a focus on social actions. This process was different from line, by line coding and resulted in many open codes having multiple references within the data. NVIVO nine is able to track the number of references within each open code and this was important because some open codes were elevated to focused codes and this was, in part, because they represented many instances within the data.

In vivo codes, using participants’ own language or terms were used to act as symbolic markers because such insider shorthand terms often reflected important social constructs. In the present study, service users, mentalization therapists and art therapists tended to use different terms and where similar terms were used it could not be assumed that the same meaning would be intended. Terms were viewed with suspicion and subject to analysis by unpacking implicit meaning through the constant comparison method. For example, service users referred to an exchange where art therapy groups became “gobby”. The meaning of “gobby” became clearer when it was linked to further statements where service user observers described group members becoming provocative to each other more, with a sense of violence becoming more possible. This sense of provocation had been picked up in other groups, but named differently.

Initial coding required a great deal of time because such codes would form anchors to the data for all further levels of abstraction and so needed to reflect that data well. With

all codes being checked with the data at least three times, and a supervisory check from my research supervisor, the process of open coding eventually resulted in 406 open codes.

Focused coding. Focused coding increased the level of interpretation applied to open codes in order to synthesise them into larger segments of data (Charmaz, 2006, p. 57). These larger segments needed to make analytic sense in terms of focusing groupings of open codes towards hypotheses of social action. Naming a focused code involved occasionally elevating an open code to a focused code.

Axial Coding. Axial coding is a process of treating a category as an axis around which to analyse its relationships, properties and dimensions. Charmaz (2006), adhering to Glaserian principles, viewed the use of axial coding as described by Strauss and Corbin (1998) as an "optional rather than a mandatory step in the process at this stage" (p. 60). Her criticism was that axial coding might influence the researcher to apply the procedure too rigidly, as if it were a set of rules, and thereby make the researcher overly passive in pursing theoretical coding as they encounter it. However, she admitted axial coding could be a useful step for those new to grounded theory, as I was, on the condition that their attitude remains sensitively flexible to data and active in the pursuit of theory, rather than schematic and robotic. I undertook axial coding at this stage.

Theoretical coding. This aimed to reconstruct the story fractured by earlier coding back together by specifying the possible relationships between groupings of focused codes. This process involved a further rise in the level of active interpretation by the researcher beyond focused coding. Theoretical coding included the use of both theoretical memos and diagrams. Theoretical memos involved my explicit speculation about the possible relationships between codes and writing those speculations in narrative form. Whilst many of these speculations remained hypothetical, some memos had the effect of revealing new relationships between focused codes in the data that had not previously

been visible. Likewise the use of diagrams helped to plot out how the merging groups of codes might relate to each other and where contradictions appeared. This eventually proved to be a more revealing approach than axial coding.

Theoretical sampling. This process required the development of theoretical codes to be re-applied to the data to find new insights into theory. This involved looking for both events where similar phenomena occurred and events which were dissimilar. Charmaz made a distinction between dissimilar events and the concept of sampling for negative cases as used within quantitative research, where the aim is to find new variables (Charmaz, 2006). The aim of theoretical sampling is to explicate the properties of the theoretical code by constant comparison. The focus of theoretical sampling was on actions, not on individuals, whilst acknowledging that certain individuals might show the given variant as per social construction epistemology.

Conceptual categories. This process involved amalgamating theoretical coding into conceptual categories and forming an analytic concept which had overriding significance. The specific steps included grouping codes, abstracting common themes and patterns from several coding groups and the revision of existing codes through renewed theoretical sampling. Conceptual categories were considered theoretically sufficient when they described the properties in terms of the conditions under which it operated.

Integrative diagrams. Urquhart (2013) recommended that until categories are related then analysis has cannot claim to have been pursued to the level of a theory. Strauss (1987) recommended the use of integrative diagrams for this purpose. Integrative diagrams depict core categories in boxes and locate the relationship between categories as lines. The relationship those lines represent are then named. Strauss recommended integrative diagramming should be a continuous process, linked with theoretical memoing, with one diagram building upon another. The original Glaser and Strauss (1967) model

recommended that where possible conceptual categories should then be further related to each other in order to result in one to two meta-level, core categories. The final integrative diagram should identify the core categories by the number of relationships that link to, or terminate in them. The final integrative diagram for the present study is presented in the results chapter.

Having outlined the grounded theory approach I would like to describe how the issues of my undertaking a practitioner-researcher role and the use of limited data were addressed.

Strategy for addressing my dual role of treating art therapist and grounded theory data analyst. As stated in the epistemology, it was not the aim of the research to exclude the observations of the treating art therapists, as if that would confer some form of objectivity onto the grounded theory. Instead, the aim was to include the treating art therapists but widely increase the range of perspectives used to describe the video edited sequences (Figure 25).

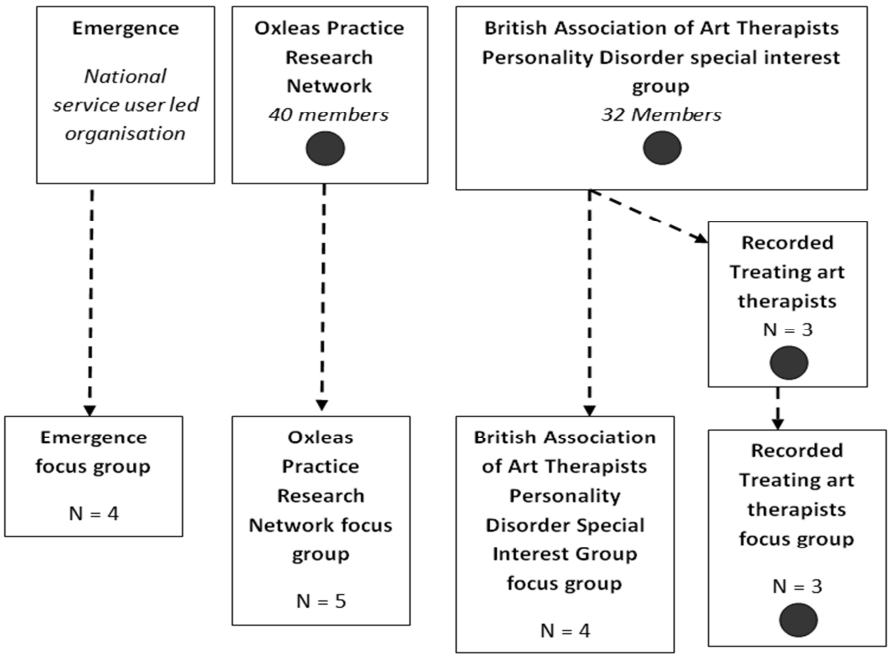

Figure 25. My social positioning within the present study. The dotted line represents recruitment and the black dot indicates my membership of the respective groups.

Figure 25 revealed the positioning of my voice amongst 16 observers in the focus groups and also demonstrated the independence of the service user focus group. The multi-category focus group design as was previously introduced (Figure 23) meant that the treating art therapists were the final focus group within the sequence of four focus groups. Within that last treating art therapists' focus group I only contributed after my fellow focus group members had spoken. A sample transcript of this focus group is presented (Appendix K) to demonstrate that process. This was to ensure that I had minimal impact on them giving their initial impressions of the video edited sequences.

However, whilst I was only one of 16 focus group participants, I was the sole grounded theory analyst. When it came to analysing the focus group data I bracketed my involvement in two ways. Firstly, through reflection in the research diary (Appendix A) and where particularly relevant I included extracts in the discussion (chapter 7) and secondly, by distinguishing between adding to theory and adding to data. For example, whilst I was undertaking grounded theory approach I continued to run my weekly MBT art therapy groups and this inevitably affected how I developed the theory. But these insights were not introduced as data. I added to the *data* when I participated in the final focus group. I added to the *theory* through memoing and theoretical sampling which included my continued experience in my weekly art therapy group. Initially this involved developing questions for theoretical sampling between each focus group. At the second stage of grounded theory analysis I used theoretical sampling within the existing data set to try to find new insights into the underlying social patterns it contained. I found that continuing to run my MBT art therapy group initially challenged some of the simplistic patterns that I initially attempted to find in, or impose on, the data. It also suggested new ways of combining codes. However, I was clear that any pattern I found had to be supported by the existing data from the focus groups.

Considerations about grounded theory analysis from a limited data source.

Highly sensitive ethical issues involved in gaining video recording of *in vivo* clinical art therapy practice and in their observation by external parties in focus groups meant that only a limited number of video recorded sequences could be obtained within the confines of the present study. Likewise, the focus groups had a limited duration because they involved busy service user researchers and clinicians who, whilst they made substantial commitments, could in reality only give limited time to the study. Whilst it would have been possible to contact focus group participants after the focus group this would have offered limited value. This was because I did not consider recollections of the video edited sequences given weeks or months after seeing them to be comparable to the data generated by discussion from immediate observation in focus groups.

I wish to describe how these limitations were considered in relation to grounded theory approach used in this study. The original model of grounded theory proposed by Glaser and Strauss (1967) assumed that sampling would be theory driven from infinite sources of data. The above practical limitations required some modification be made to the grounded theory method with respect to theoretical sampling within a limited context. However, I have already described in the epistemology section of the present study an argument by Dey's (1999) for the concept of theoretical sufficiency to replace theoretical saturation as less positivistic, more justifiable description of what grounded theory seeks to achieve in theory construction. The original assumption of infinite sources and theoretical saturation has been frequently challenged by later proponents of grounded theory who have used it to describe actions within social phenomena which have been equally limited because of the difficult of the gaining researcher access. In particular, limited sample sizes have not been uncommon within grounded theory health studies where similar ethical constraints apply. Theoretical sufficiency has been used to justify theory constructed from

limited populations of less than 12 individual interviews (Crowther, Goodson, McGuire & Dickson, 2013; McCreadie, Wiggins, 2009). Theoretical sampling would continue with a return to the data, rather than a return to the field (Timmerton & Tavoy, 2007).

The data were generated by a range of observers describing video edited sequences of art therapy practice. The risk of using a limited data set was that it might not provide enough material to achieve theoretical sufficiency. However, it could be argued whilst this approach produced a data that was limited, that data was also complete. The data set was limited because there were only three video edited sequences and four focus groups. The data set was complete because it represented how those focus groups described what was obvious to them from their immediate impressions of those video edited sequences. I therefore saw my analytical task as to theorising how *those* four groups described *those* three video edited sequences so I had some confidence that this more limited task would be achievable. I discussed with my supervisor that the greater threat to theoretical sufficiency would be that each focus group saw something so different that no theory could encompass that breadth of contradictions with any validity. However, if the study showed that art therapy could not be observed by the above method, I argued that would be a valid result as it would still add to understanding how theory can be built in art therapy.

Quota and theoretical sampling. Another consideration within the limited data was that because each focus group was internally homogenous, representing a specific population, but heterogeneous to each other as per the multi-category design, the study involved a form of quota sampling. Charmaz (2006) made the following differentiation in respect to this in grounded theory: “Theoretical sampling is a strategy, not a procedure and it depends on your purpose. Theoretical sampling is not quota sampling, an attempt to represent a population, it is purposeful sampling according to categories which develop

from ones analysis" (p. 101). This therefore required two modifications to the grounded theory approach. I addressed this by using the interview schedule (Table 10) in each focus group firstly, to gather first impressions (quota sampling). Secondly, I asked the focus group moderator to then introduce questions which were developed through my theoretical memos about the data from previous focus groups (theoretical sampling). This method introduced theoretical sampling but also preserved the important first impressions from a range of perspectives I was keen to gain as per the social constructionist epistemology.

Chapter Seven: Findings

The grounded theory method is an iterative process where the findings from one stage of analysis drive the sampling processes taken in the next. Many qualitative researchers have therefore suggested that the presentation of grounded theory finding cannot be completely separated from a discussion section, as they might be a quantitative experiment where the parameters would be set from the start (Urquhart, 2013). For the purpose of this thesis the finding chapter will be presented in the following manner. I start with a description of the major analytic decisions that were taken to construct the grounded theory, I then move onto a description of the grounded theory that resulted and then finish the chapter with a discussion about the validity of the processes used.

The grounded theory is presented using the following structure:

- Tables showing the relationship of open codes, focused codes to conceptual categories
- An integrative diagram showing the relationship between conceptual categories with a narrative description conceptual categories as they relate to two core conceptual categories
- The grounded theory as a set of propositions.

I now begin the first part of the findings chapter by describing the grounded theory construction process.

Constructing the Grounded Theory.

The grounded theory construction process involved many iterative combinations of codes and a great deal of theoretical memo writing. It was neither possible nor helpful to present all data involved in decision making in a document of this size. Therefore I select examples from my coding and theoretical memos which demonstrate the major analytic decisions that drove theoretical sampling. This process involved two phases:

theoretical sampling between focus groups and theoretical sampling from the data. I will describe both, beginning now with a description of the steps undertaken to theoretically sample between the four focus groups.

Sampling between focus groups. For all four focus groups the following steps were repeated: (1) I listened to the audio recording and produced a verbatim transcript; (2) I then undertook open coding using gerunds as was previously discussed (reference the page number and (Charmaz, 2006, p. 48). As analysis of the focus groups progressed further open codes were developed. Data references in the form of quotes from the audio transcription were added to the emerging open codes if they appeared to support an emerging pattern or be a good theoretical "fit". New open codes were created to accommodate text which did not fit existing open codes, thereby increasing the total number of open codes as the focus groups progressed.

After each focus group I grouped open codes into focus codes (Charmaz, 2006, p. 57). I did not fully exhaust the allocation of open codes to focus codes at this stage. To do so would have prematurely risked categorising or the data. My intention at this point was to use focus coding to begin to identify patterns in the data, which I could then develop through theoretical memos. Having formulated memos, I then developed questions which I discussed with the focus group moderator as a means of theoretically sampling between focus groups. The method used for this was as follows: The focus group moderator began the focus group by following the original interview schedule (Table 10). The purpose of this was to not interfere with the focus group's process of describing their first impressions of the video edited sequences. I was interested to see if the focus group would spontaneously raise either the same or different issues as a previous focus group immediately after having observed the video edited sequences, as this might yield important insights about what each population saw in the art therapy group. Where focus

group participants did not spontaneously address the issues that I had identified for my theoretical sampling questions in response to the interview schedule (Table 10), the moderator added them in. Asking theoretical sampling questions at the later point in each focus group allowed the some discussion about why the issues they contained may not have been prioritised by the focus group participants as *their* initial description of the video edited sequences. To summarise, the process then, the initial aim of the sampling strategy to gather new perspectives from each population as quota sampling and to pursue grounded theory theoretical sampling after that.

The process of theoretical sampling resulted in large amounts of memos. For the sake of brevity and clarity of argument I now summarise the main theoretical sampling decisions taken between the remaining focus groups.

Theoretical sampling from focus group one (Emergence) to focus group two (psychological therapists). Focus group one resulted in 290 open codes. I attempted to group as many of those open codes into focused codes, which resulted in the following focus codes: Focus on the artwork; chaos in the group; emotional tone; longitudinal processes in the group. I then made numerous memos about patterns that focus coding had suggested to me.

By way of example, I now outline the relationship between data, open codes and theoretical memos as it pertained to the focus code "emotional tone". Two examples of open codes named "art therapist appearing disinterested" and "art therapist engaging emotionally" were part of the "emotional tone" focused code. The open code named "art therapist appearing disinterested" contained the following references from the data:

> Participant B responds to video edited sequence two: "(the art therapist) might as well as not been there really... I image when he leaves the room the group will just keep on going ... do you know what I mean?"

Participant A responds to video edited sequence two: "It's like the art therapist lost interest ... The (videos edited sequences) have made me realise like in terms of personality disorder I think we need a bit more presence from the therapist ... I feel ... like this is specifically this therapy for personality disorders isn't it? So I feel actually, I'm starting to think that in terms of art therapy: get a bit more involved because I have observed in art therapy people ... art therapists hang back a lot."

The open code named "art therapist engaging emotionally" contained the following references as quoted from the data:

Participant D responds to video edited sequence three: "I thought the therapist was displaying quite a lot of quite genuine, seemed like quite genuine, curiosity asking questions like to really try to understand the experience and what was going on for her in a way that I found quite ... mmm, touching ... it was kind of very engaged."

Participant C responds to video edited sequence three: "Yeah ... because I think you can tell if somebody is erm ... it's that fine line, if somebody is too involved and kind of overstepped that erm over-empathising boundary you don't feel safe and at the same time if someone is very erm cold or doesn't seem to give a crap then that is also kind of you can ...it's almost like a beacon or radar that you can tell that what you have there is a nice balance, it didn't seem to erm go off into past either boundary."

After grouping open codes into focus codes I then wrote a number of memos which sought to explicate the relationship between the emotional tone and what actions the therapist was taking. The following is an extract from my final memo in that series:

> "I was surprised by what had been revealed by this focus group. I realised my expectation of what observers would describe had become rather narrowly centred on actions. This may have been because the feasibility study focus groups had been very strongly concerned with describing the actions they saw the art

> therapist take in the video edited sequence they viewed. By contrast this focus group consistently kept referring back to the emotional tone of the art therapist in the session. They seem to be indicating that the therapy is not only about what the art therapist does, but how they do it. I need to find a way to understand the relationship between the actions the art therapist takes and this centrality the Emergence focus group placed on emotional tone. My questions therefore are: What is the action that gives viewers a sense of emotional tone? What is the relationship between art therapist emotional tone and the outcome of the group therapy?"

Having formulated these questions I then discussed them with the focus group moderator prior to him undertaking the next focus group.

At focus group two, which consisted of the psychological therapists, the issue of emotional tone of the therapist was not spontaneously raised within the discussion so the focus group moderator introduced it. The focus group participants responded that they observed that the art therapists generally spoke openly about their own emotional response to the artworks in the group. The psychological therapists in focus group two noted that in the second video-edited sequence the art therapist sat back and sighed, which they thought was "quite rude". However, the psychological therapists quickly moved from these descriptions and did not link them to actions. I noted in my memos that this group of psychological therapists were not foregrounding emotional tone to anything like the same degree as Emergence. However, I still felt emotional tone was important to understand and would ask for this to be returned to with the next focus group.

In addition to coding data to existing open codes, this second focus group resulted in the development of new open codes, bringing the total open codes to 320. Developing new open codes had implications for the shape of the theory I was developing because new

combinations of open codes were now suggested. This demanded a new level of the constant comparison approach as follows. I reviewed new open codes for their fit to existing focus codes. I then examined what new focus codes might be suggested the remaining new open codes. I then reviewed the fit of all open codes to focus codes and reallocated open codes to focus codes where the fit was stronger. This resulted in the following focus codes: Role of the artwork; chaos in the group; emotional tone; focusing on the lifespan of the session; tension between individual focus and group focus.

I noted in my memo that the psychological therapists had generated more focused codes around the way that the art therapist negotiated between giving attention to the art maker and their image and giving attention to the group. It struck me that the element of having an artwork in a group therapy setting seemed to be more novel, as unlike the Emergence group, not all had been involved in an art therapy group before. There were many comments that when the art therapist focused on the artwork this left some other members silent. Some actions by group members, such as making obscene gestures or texting in the group were not commented on immediately by the art therapist. A psychological therapist from the focus group summarised that tension: "I was really struck by the uncertain relationship with group process and how to balance attending to the group with the artwork and achieving some depth in exploring the individual experience."

The psychological therapists identified that the presence of an artwork in the group setting changed the group structure very much from a verbal group. This was crucial for me to understand, as it may be indicating a unique feature of art therapy groups and as such related directly to the research question. One of my open codes entitled "Looking at artwork puts service users in roles" proved to be quite pivotal in understanding this issue. This was the text it contained:

> Psychological therapist focus group participant, responding to video edited sequence three: "For me, only what we've said already around ... you know there is something about presenting (an artwork) isn't there and how it ... what you choose to present and what you don't and the position it puts you in when you are being asked to describe something , I think that ... and how the people listening were invited in took or up to support it in a supportive role like you said in turn or sharing or the person in middle."

I made numerous memos to try to understand what had been raised about how the presence of the artwork created roles for members of the group. I asked the focus group moderator to raise the role of the artwork as well as emotional tone in the next group.

Theoretical sampling from focus group two (psychological therapists) to three (art therapists). Interestingly the art therapists' focus group spontaneously commented on both the emotional tone of the art therapist and the role of the artwork. This focus group was critical of the emotional tone, use of the artwork and management of communication in the group in the second video edited sequence. Following the art therapists' focus group I coded data to open codes, resulting in 370 open codes. I regrouped through constant comparison open codes into new focused codes as follows: Role of the artwork; chaos in the group; emotional tone; maturational processes; tension between individual focusing on the lifespan of the session; focus and group focus; reflective processes; problematic interactions in the group.

I wish to describe the approach to the refining the focused coded entitled "emotional tone" as an example of the process of theory development at this stage. One of my open codes, "art therapist not interacting", contained data taken from the focus group's very first reaction to video edited sequence two:

Focus group participant one: "mmm ... that does feel hard to respond to ..."

Focus group participant two: "Yes, it does feel different to the last clip"

Focus group moderator: "What makes it hard to respond do you think?"

Focus group participant one: "Well, hearing it was hard, erm ... and it's made me think about my practice and like oh my god, I'm like Attila the Hun in the room or something!"

Whole group laughs.

Focus group participant one: "I wouldn't have had that much over-talking"

Focus group participant three: "No"

Focus group participant one: "I just would not have had that going on so I am a bit perplexed erm ... It felt like, I'm sorry, I know this sounds negative, it seemed like a bun fight sometimes. I just would have had to have intervened. I got snippets of what, if I am being constructive as I can, this is a long term group they've got in there, they are talking about relationships, they are obviously able to challenge each other, they are talking about where there has been dysfunction in the family and I give the group and the therapist credit for that ability to have come about in this group, but there was no interaction with the artwork, it didn't get referred to again, nothing was visible, I felt the therapist, perhaps, could have intervened more. So I need to be quiet now and just think about how the research questions fit with this except because I am struggling ..."

Many observations made by the art therapists matched those by Emergence closely, with a sense that the art therapist was too passive in response to an art therapy group which was becoming chaotic. This focus group perceived that once the artwork had been mentioned it was not referred to again and as consequence the art therapy group becoming more volatile. They noted that when the art therapist did eventually become more active, it did not seem reflective, but became part of the rising chaos in the group. The focus group

referred to the group as a "bun fight" with everyone throwing new ideas into the conversation without reflecting on what had already been said. Focus group participants were keen to point out a disparity between group talking from group communicating in this sense. One of my open codes was "art therapist adding more content to discussion" contained the following data:

> Art therapist focus group participant four responding to video edited sequence two: "Yeah, but he (the art therapist) didn't pick up on or deepen the conversation as it was happening saying "and how do you feel about that?" and stuff, you know "someone just said this" ... or was there a little bit of that actually with the sex? He did bring that back though ... but I was struck by he seemed to bring in something completely different which I could see the point of but it was in a bun fight as you call it and it was another bun to be chucked in and it didn't feel like there was any ... it didn't deepen or sort of focus down on any one thing."

My memos at this point showed that I was struggling to understand different types of art therapist activity. "Art therapists adding more content to the discussion" was very helpful in defining one art therapist's activity as stimulating reflection on existing content, rather than adding new content. On re-reading all previous transcripts I altered a number of open codes to capture that differentiation.

The focus group participants also observed that role of the artwork had been different in each. This added a new dimension to my coding about the role played by the artwork, that it may have different roles in different circumstances. I identified one circumstantial variable as group maturity, defined as group member's ability to autonomously reflect without the art therapist's direct support. For example, I open coded the following comments to "groups maturing":

> Art therapist focus group three participant referring to all three video edited sequences: "It almost sounds like, obviously in the last film, but three different films represented three different stages so perhaps the middle film could have been the first stage where people aren't yet at the point where they are ... they haven't got that idea of what it is they are actually meant to be doing, they are trying to find out and then the middle group in film one, where people are getting the hang of it and this film where they have got the hang of it."

I noted that this observation had also been made by an Emergence focus group member comments on video edited sequence three open coded as "going deeper":

> "Yes... but it was a different level of therapy to the other two, we kind of got progressively deeper so the first therapy session was just trying to get people to talk and the second was trying to talk about an established issue and this has really got to a proper core issue that made everyone uncomfortable even us who were not there in the room (laugh)."

I then grouped the relevant open codes to a new focused code entitled "maturational process".

The art therapists' focus group also identified a correlation between the art-maker's increased reflection on the artwork and an increased in their confidence to be with other people in the group. As the art therapist focus group participants described it:

> Focus group moderator: Do you think you saw therapeutic change happening?
>
> Focus group participant one: I did feel that when the first person introduced their artwork it was kind of dismissive and it was bouncing it in between the group members and making it more like it deserved to be here it had a state of being I think that the exploratory questions and opening up the group sort of seemed to ... and the maker seemed to sort of "yeah, this is me."

> Focus group participant four: "yeah, I think the chap who talked about his image first as you said (focus group participant one), by the end of that whole interaction he seemed to be more present in the room, so yeah I think that was definitely a change."
>
> Focus group participant two: I felt he connected to his image instead of “oh this is a thing that says I can’t really whatever”. In fact there was an integration of something ... it seemed he felt quite competent or quite proud that it conveyed something of his state of mind and he got it."

My memos at this point were concerned with bringing together the insights that I had accrued so far. A picture was emerging where the art therapist used reflection about the art-makers artwork to help that service user somehow feel more confident within the interpersonal situation of the art therapy group. This action involved a tension between a group focus and an individual focus within the art therapy group, as described by the psychological therapists. When groups matured that tension was less evident because the group reflected together without direct support or direction from the art therapist. Emotional tone seemed to play a part in creating a therapeutic outcome but I did not yet understand how. I asked the focus group moderator to ask additional questions about maturity in the group, tension between individual and group and about emotional tone.

Theoretical sampling from focus group three (art therapists) to four (treating art therapists). Focus group four involved the art therapists who had submitted video-edited sequences, which included myself. As stated in the methodology, the focus group moderator introduced the rule that I would only speak after the other two participants. I attempted to give my immediate opinion on the video edited sequences but recognised that I would not be free from prior knowledge of other focus groups. I used my research diary and theoretical memos to explicitly reflect on the theory I was developing and bracketed

some of my feelings and thoughts where they might blind me to new patterns in the data. I also I differentiated how prior knowledge of other focus groups had shaped my views from divulging the content of other focus groups to fellow participants in this focus group. These processes were outlined in the methodology and reflection presented in appendix A and where relevant in the discussion chapter. Remarkably, seeing and then reflecting on the video-edited sequences within this focus group seemed to fill me with many new impressions which further developed my thinking about their content.

Much of the focus group discussion was about us all recalling how hard to it had been to not let the art therapy groups depicted on the video edited sequence slip into chaos. Each treating art therapist had attempted to try to find a focus that the group could share to manage that potential chaos. This focus group produced contextual detail about how particular service users had been functioning prior to the video-edited sequence and why it had been selected as good practice example of art therapy. There was a little discussion about the difference in therapist activity in video edited sequence two, but less so that had been highlighted by all other focus groups. The treating art therapist described how that particular service user had generally been silent but the video edited sequence showed the first time she had been able to speak for herself in the group and so he gave her space.

Gaining the view of the treating art therapists involved in video edited sequence two introduced a new perspective. However, that new perspective altered surprisingly little of the picture that I was building from the data from previous focus groups. In my memos I noticed that I could only tell that his intention was to help the service user once he had described it in the focus group but I couldn't tell from the video-edited sequence alone. Like other focus groups without his additional explanation I could not see how the video-edited sequence showed how art therapy or the mentalization model was helping her. This interested me, because it helped me to consider a new angle on the missing link between

action and emotional tone. Perhaps I could consider that emotional tone might need to be communicated explicitly through action and words as a primary aim of the art therapist. The art therapist may have all sorts of intentions, but without signalling them they remain invisible and therefore perhaps inert. Therefore the art therapists action may in some way be in the service of communicating emotional tone. I memoed that I would be interested in theoretically sampling the data to see the effect of where focus group observers highlighted that the art therapist had explicitly signalled their intention and emotional stance.

On completion of this last focus group I coded the data to open codes which resulted in 406 open codes. I allocated open codes to my existing focus codes and created new focus codes where there was a fit for the remaining open codes. I still was concerned not to force the data at this point so not all open codes were allocated. This resulted in the following focused codes: Role of the artwork; chaos in the group; communicating emotional tone; maturational processes; recruiting group to a shared focus; signalling intention; tension between individual focus and group focus; reflective processes; problematic interactions in the group.

I had now completed all four focus groups and would like to summarise the position this had brought me to before describing how I moved to a secondary strategy for theoretical sampling within the existing data set.

Summary of theoretical sampling between focus groups. The following (Table 10) shows the entire data.

Table 10

Word count by video edited sequence and focus group

Focus Group membership	**Video edited sequence**	**Transcript word count per video edited sequence viewing**	**Total transcript word count per focus group**
Emergence	One	5918	15460
	Two	5471	
	Three	4071	
Psychologists	One	4059	12661
	Two	3426	
	Three	5176	
Art therapists	One	5456	14977
	Two	5031	
	Three	4490	
Treating art therapists	One	5074	14348
	Two	5143	
	Three	4131	
Total twelve groups	Each video edited sequence viewed by four focus groups	Total word count 57,446	

There was not a great variance in word count between focus groups, more between the video-edited sequences discussed within each focus group. I noted that I felt inhibited commenting directly to the treating art therapists whose work was represented on the video edited sequences. It seems likely this effect would have been present if the treating art therapists had been included within other focus groups and I felt it was useful that they were separated.

Each focus group population emphasised different aspects in the video-edited sequences. These could be summarised as: Emergence highlighted emotional tone of the therapist; psychological therapists, the tension between individual and group focus and role of the artwork in creating roles; art therapists, the emotional tone and the role of the artwork; and treating art therapists as the need to bear in mind a particular person's history

and respond to new actions in the group. Each focus group commonly identified turn taking structures, the interest the group could show in the artworks and the different ways that artwork could be focused on either by reflecting on what had been said or by adding content. Each group also highlighted how chaotic the groups could become and how difficult it was for many service users to seem to be in the room.

At completion of each focus group I began to tentatively write theoretical memos bringing together the focused codes but still remaining open to new information. As I progressed through each focus group an overarching theoretical direction began to be sketched out which I saw as art therapy groups involving a tensions between a whole group focus and an individual focus. The treating art therapists seemed to direct the group to reflect on the artworks as a means of helping service user to feel more confident within the interpersonal setting of the group. The treating art therapist undertook the role of directing attention more when the group was chaotic. Focusing on an artwork allocated group members to roles as either the maker of that artwork or as the viewer of an artwork made by another group member. The treating art therapists directed reflection much less when the group was more cohesive, a group condition described by focus group observers as "mature" because group members had taken on the task of directing and sharing in a focus independently of the treating art therapist. It was possible that the art therapist communicated their emotional tone through the actions they undertook. I had little understanding of the consequences of each action but a pattern was emerging that therapist passivity resulted in group chaos and emotional engagement resulted in the group cooperating more.

Having completed all four focus groups I still had a number of open codes which were not allocated to focus codes. There was also great variation in the number of open codes allocated between focus codes, which indicated that some of the more populated

focus codes may have needed refining or even represent the beginnings of conceptual categories. I had not built conceptual categories at this initial stage because I was concerned to keep the coded data as close to the participants own voices as possible and not force the data and I had not discovered sufficiently clear patterns of codes to warrant any categories through my first strategy. My aim at this first point had been to use coding to develop memos for theoretical sampling between groups. I would address the problem of unallocated open codes, crowded focus codes and the construction of conceptual categories through a secondary strategy of theoretical sampling from the data to explore patterns which were not immediately apparent as described below.

Theoretical Sampling from the Data.

At the point of completing the focus groups I had not completed the grounded theory analysis. This was because I did not consider the analysis to be a simple linear process where one focus group added to the data of the next. Instead constant comparison method indicated that patterns identified in later focus groups would have implication for understanding patters of earlier focus groups. I therefore wish now to outline how I continued to re-examine the existing coded data. This continued the process of allocating open codes into focused codes and then into conceptual categories but also began to define the links between conceptual categories via diagramming, where lines were drawn between conceptual categories and were then named as theoretical codes. Theoretical codes were then retested against the data by the constant comparison and memoing methods (Charmaz, 2006). This continuously revealed faulty or anomalous theoretical constructions which were not supported by the data as will be described below. Only after several rounds of restructuring at all levels of coding could theoretical sufficiency be achieved. This was a lengthy process and again, my intention here was not to present all details involved but to summarise only the key decisions, giving examples of codings,

memos and diagrams. I start by explaining the process where I addressed the theoretical deficits I had at that point in the analysis in relating the art therapist strategic actions from the condition in the art therapy group.

Axial coding. Charmaz recommended that having fractured the data through open and focused, an initial step in approaching the whole data could be to strengthen conceptual categories by regroup all focus codes by the following axial coding criterion:

1. Conditions – circumstances that form structure of studied phenomena
2. Actions/interactions – Participant's routine and strategic responses to events
3. Consequences – "why", "where", "how come" (Charmaz, 2006, p. 116)

The aim at this point was to challenge existing codings by reassembling all codes and categories into these three groups, checking for cases where the issue did or did not apply. Because I was specifically interested in understanding the actions of the art therapist I translated Charmaz's three points into the following questions:

1. What circumstances form the structure of the art therapist's action?
2. What is the art therapist's strategic response to events?
3. What, why and where are the consequences of the art therapists strategic responses?

I applied these questions to my open codes as the first stage of theoretical sampling within the data. This altered my focus codes, increasing their number and redistributing existing out open codes more accurately between them. I found that I could allocate more open codes to focus codes without forcing the data by this method. On completion I was able to develop my first tentative conceptual categories by grouping focus codes. This initial restructuring on the data is represented in Table 11.

Table 11

Initial result of allocating coding to circumstances, strategic response and consequences.

What circumstances form the structure of the art therapist's action?	
Focused Codes	**Conceptual Category**
Doing things in therapy that you can't outside Identifying different safety valves Identifying maturation in group process Patients and therapists reflecting together Peer relationships as therapy Properties of art in an interpersonal setting therapeutic group culture	Art therapist draws on contextually existing therapeutic features in art therapy.
Being with other people in the group is difficult Finding art difficult Finding oneself difficult Putting the therapist out of role	Inherent challenges about being in an art therapy group for those with BPD
What is the art therapist's strategic response to events?	
Focused Codes	**Conceptual category**
Asking reflective questions Becoming more forceful if content is inappropriate Choosing to attend to only one thing at a time Judging then responding Being emotionally present Fostering a group led culture Giving space to new phenomena; Validating	Art therapist chooses types of here and now focus
Directing focus back to the art maker Drawing on turn taking structure Implicitly creating an image focus Needing a long time to talk about art Responding to art by making a narrative Therapist becoming just a viewer by offering different perspectives Therapist connecting patient to their art by reiterating what they said and did in group Using image to bring in other group members	Art therapist directing a focusing on the art
What, why and where are the consequences of the art therapists strategic responses?	
Focused Codes	**Conceptual category**
Articulating physical sensation Celebrating in the face of challenge Developing interpersonal and emotional congruity Developing view of art as self-representation Softening perception by sharing	Therapeutic outcome for service user

I found that this method better re-clarified the therapist's actions from the circumstances in the group. I did find though that those circumstances and outcomes in question one and three were often repeated and could have been allocated to either category. Through memoing, diagramming and constant comparison, I was able to identify this was due to a stepwise approach in the art therapist's action. This is an extract from one of my memos where I attempt to describe that:

> "A stepwise action appears to be where the art therapist responds to chaotic interactions in the group by bringing the focus down to a simple, single focus. Only when most of the group has engaged and there is some reduction in chaotic behaviour does the art therapist then move stepwise onto a second action which is to widen their focus. So the art therapist responds to chaos by quite forcibly favouring an image focus over all other phenomena in the group. This results in a state of pause in the group where people sit, look at and discuss one image. In doing so they are re-allocated to roles as art maker or art viewers. This consequence, if it is achieved, then becomes the circumstance for the next strategic response from the art therapist which is where they attempt to make widen the focus by making links between images and other group members. Stepwise is not always linear progression from beginning, middle to end. It seemed the art therapist had to reverse the steps frequently."

This memo helped me to link what appeared to be a desperate set of actions together with some coherence as supported by the data generated from observers in the focus group. The stepwise process was a process of moving from a simple to more complex shared focus in the group. The artwork had a role supported this sharing of attention because when everyone focused on an artwork the group became quieter and group members seemed to find their return to roles as art-viewers or art-makers clarified what

was meant to be happening in the group. The art therapist would only move stepwise from this shared artwork focus to a more interpersonal focus when conditions allowed.

At this point I wanted to develop a level simpler way of describing the parameters the art therapist the art therapist appeared to be balancing. I decided it was that the target of focus was either simple (the art-maker's intention in making their artwork) or complex (the whole here and now of the group including connections between art-works, their makers and what had been discussed in the group). I then considered that the art therapist was attempting to recruit as many group members to a shared focus as possible and drew this in the following diagram (Figure 26).

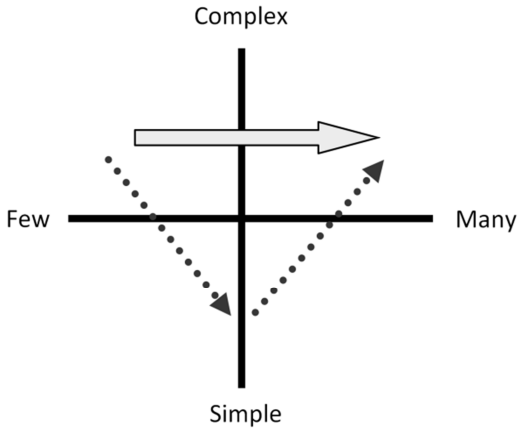

Figure 26. Vertical axis represents the target of attention in terms of its complexity. Horizontal axis represents the number of group members who share attention on that target.

Figure 26 helped me to see that the main dimensions the art therapist was considering was the relationship between the complexity of the target of attention and the number of group members who could share a focus together on it. I described it in a memo:

> Each quadrant then seems to fit what observers had described in the group. Quadrant A represented the problematic state in the group where what was happening was

complex and few were sharing attention. Perhaps it is a mistake to try to go too quickly from A to B, where many were able to share a focus on a complex issue (as represented by the yellow arrow). Quadrant B may well represent the therapeutic aim but too much haste seemed to only "add buns to the bun fight" as was described by observers in video edited sequence two. Where art therapist were more successful it was by taking the long route (as represented by the dotted line) from quadrant A, through quadrant C where the target of attention was simplified, helping more group members to focus on it as per quadrant C, and then increasing the complexity by linking images or what people said thereby arriving at quadrant B. This diagram and the identification of these two axes are very helpful in sorting out the relationship of the two types of focus the art therapist attempts as a strategic response.

Even though I had made progress in building the theory, at this point I still had unresolved relationships between codes and conceptual categories. I needed better understanding of the circumstances that determined when the art therapist would take control of the shared focus and when they would cede that control to the group. I did not understand how the art therapist directed the focus of the group whilst signalling their emotional engagement with the group. I did not know how to account for the types of communication of emotional tone in terms of circumstances and consequences. And I had by no means abstracted my theory to the point of identifying core conceptual categories. I wish now to focus on the resolution of a number of these issues to demonstrate how theoretical sampling of the data resulted in the identification of the two core conceptual categories.

Developing core conceptual categories. I was particularly interested in understanding how the art therapist could take charge of the focus of the group yet still communicated their emotional engagement with it. There seemed to be some outstanding

discrepancy between communicating emotional engagement to make group members feel included and this particular action where the art therapist directs the group to narrow down on one artwork which necessarily involved excluding all that was not within that focus. Including and excluding seemed to me to be opposing imperatives yet the data suggested when the art therapist either narrowed their focus down onto one art work or communicated their emotional engagement it had a helpful effect in the group.

I created a theoretical code entitled "focus down on one artwork". I reallocated all open codes to that focus code that fitted it conceptually. On re-examining the data contained in the newly grouped open codes I found that the treating art therapists only "focused down on one artwork" under certain conditions, namely when the group becoming more chaotic and reflection decreased. When the group was reflecting together the art therapist did not intervene in this way. This helped to show that "focusing down on one artwork" was a strategic response to a particular chaotic circumstance and not a routine action applied to all situations.

However, having identified "focus down on one artwork" was a response to the condition of the group becoming chaotic, I did not know if this was the only response the art therapist took to that condition. I therefore created a conceptual category called "group becomes chaotic". I re-grouped all focused codes that fitted that category and looked for dissimilar events as described by Charmaz, (2006, p. 60) where the art therapist did not respond by "narrowly focusing on one artwork." I then rechecked that open codes still fitted the focus codes in their new locations in the categories, which they did not and that then resulted in the reallocation of some open codes to new focused codes. This revealed two distinct responses from the art therapist to the condition of "group becomes chaotic." These two responses were: 1) an existing theoretical code entitled "Focus down on one artwork" and 2) a new theoretical code which I titled "art therapist appears passive". "Art

therapist appears passive" nearly exclusively contained data from video edited sequence two, where focus group observers described the art therapist giving an apparently passive response to the group when it was becoming chaotic and less reflective.

I now had two responses to "group becomes chaotic", namely "focus down on one artwork" and "art therapist appears passive" but did not know if those two responses from the art therapist had different effects on the group condition. So I then re-examined the data that had been coded to "art therapist appears passive" and contrasted it with the data that related to outcomes from all remaining art therapist actions. I found that when the art therapist responded to the group's condition of "becoming more chaotic" with "art therapist appears passive" the data from the result of that response lent support to the idea that therapist passivity further exacerbated chaos and reduced reflection in the group. Conversely, the remaining data which concerned the more active response of the art therapy showed the opposite, that the group became more cohesive. I named the codes that indicated the result of "art therapist appears passive" to a conceptual category "decreased reflection".

I then returned to my question about how directing a narrow focus by "focus down on one artwork" did not seem to result in group disintegration, even though it involved the art therapist excluding material. I developed the following memo to account for the inter-relationship of these issues.

> "In my diagrams I have struggled to link the way the art therapist communicates their emotional engagement with their insisting on an art focus. I am particularly stuck wondering how focusing down on one artwork does not alienate group members. The data in fact shows that far from alienating group members, it seems to engage them.

As an experiment I asked myself what is the alternative to narrowing down the focus in a chaotic group? Focusing on everything would be so would be very frenetic and so confusing. Isn't a focus on everything an oxymoron? You can't focus on everything, like you can't prioritise everything. By definition, a focus means look at *this* and not look at *that*. One could only focus on everything by sitting back and "appears passive" as per video edited sequence two which then risks looking like you are focusing on nothing. A focus stops the group interaction becoming confusing to the art therapist and the group members. Maybe this narrowing down to focus on one artwork is the art therapist sort of saying "look I need to slow things down and focus so I can understand". This would be the opposite of saying "stop all this random talking so that so we can look at art", which would be silencing. Showing that you want to understand but need help to do so would not be an alienating statement, it would signal an intention to want to understand more. Perhaps narrowing the focus is done *in the service* of signalling that the art therapist is interested and emotionally engaged, that they want to slow the events and discussion in the group down so that they can really, really pay attention and understand at a deeper level.

I then diagrammed the codes as they emanated from the condition "group becomes chaotic". I then subsume the focus codes that showed the art therapists' stepwise actions within a category named "demonstrate attention" (Figure 27).

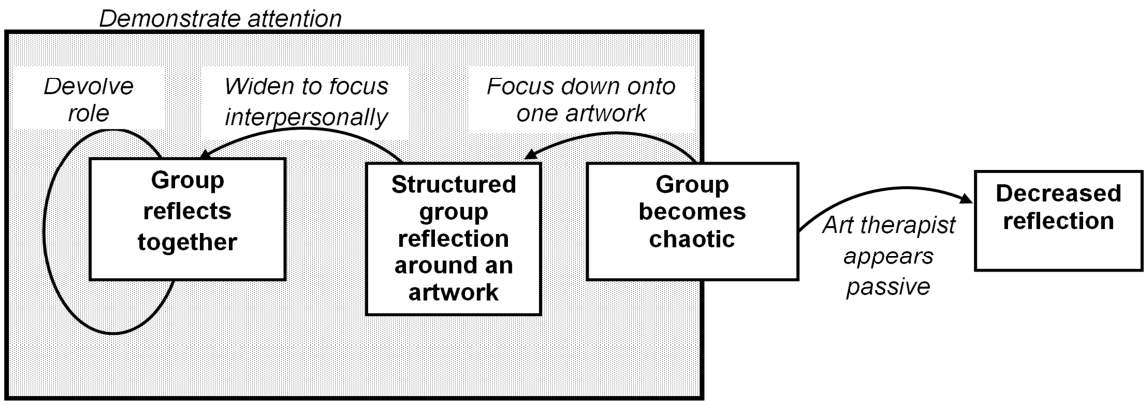

Figure 25. Subsuming art therapist action within a core category of demonstrates attention.

The diagram revealed "art therapist appears passive" might represent a mutually exclusive set of actions and consequences to "demonstrate attention", whilst all stemming from an original source named "group becomes chaotic". In this way I began to see a way that two core categories could be derived from the data. I should stress at this point that focus codes in figure 25 were only provisionally named. Each focus code contained too many open codes to accurately support this category. This was resolved through constant comparison. I included the diagram at this juncture to show its usefulness was in pointing out how the art therapist may have two distinct responses to a common condition and I could use that to direct further theoretical sampling towards two core categories. I undertook a similar process to differentiate the categories which appeared similar in the case of "art therapist appears passive" from "art therapist devolves role".

I continued to memo in order to understand how demonstrating attention could have such an important effect to make this the superior category to the stepwise actions taken by the treating art therapists after they had narrowed down to "focus on one artwork". In this memo I reflect on my experience in the focus group:

"I feel a little guilty that video edited sequence two has not been viewed by focus groups as the representation of therapeutic practice that the treating art therapist had

> offered it as. I felt better about it once he had explained his rationale in the focus group. But maybe therein lays the salient point. I only knew that this art therapist was engaged with the group because he told me in a focus group. I didn't get that from his actions in the video edited sequence, so maybe the group didn't either. No can be psychic or read minds, it's really hard to infer mental states when we are distressed. So perhaps how the art therapist shows their engagement, demonstrates it through their actions that is the operant principle that determines a good outcome"

Having created this memo, I applied the idea that the art therapist would not just go with the flow of a group but actively intervene to slow it down, not to silence it, but to understand it more. I then checked that the data supported the idea that these therapist actions would be in the service of "demonstrates attention". This construct seemed even stronger once I had done this. As quote from the Emergence focus group sums up the idea of not just being attentive, but demonstrating it:

> "Yeah, I really liked his approach it’s definitely my favourite of the three because he was the most present I think that’s ... yeah that was really important for me, he was really there, you could tell he wasn’t caught up in his thoughts he was really listening to everyone, really keeping an eye on everyone, erm and really judging when to speak and when not to speak and that for me makes for more successful therapy session when the therapist is more present erm and he , yeah was just very engaged and he asked those really reflective questions really carefully thought about what and how to say something and he also was quite affirming and he dropped in positive statements and reassurances."

Having identified the potential superiority of demonstrating attention as a core conceptual category, I continued the same theoretical sampling from the data processes to establish that the second core conceptual category was "art therapist appears passive".

These titles eventually changed through constant comparison and diagramming. The final findings will be presented in the next section which includes the revised names of categories and codes. The aim of presenting these early drafts was to show the process of theory development at the second stage of analysis, which I will briefly summarise before presenting that final theory.

Summary of second stage of analysis. Analysis between focus groups had developed focus codes concerned with signalling emotional tone of the therapist; tension between individual and group focus; role of the artwork in creating roles; the need to create a shared focus; and the need to respond to new actions in the group. Theoretical sampling within the data concentrated on differentiating all levels of coding by conditions, strategic responses and effects. This helped to develop new questions which could be applied to the data, particularly in terms of relating the action of the therapist with the emotional tone described so strikingly by focus groups. Re-applying these questions to the data revealed a clear differentiation between two mutually exclusive core conceptual categories of action taken by the art therapists.

From this point on I continued the constant comparison because I still had not reached theoretical sufficiency at all levels of coding. Finally I attempted to elevate the grounded theory from descriptive level to a set of propositions. Those propositions were then compared to all levels of data and codes. Again this revealed a number of anomalies which required attention. Therefore further analysis of the data, and careful recoding at focused and conceptual category level was required to reconcile propositions with the need for the theory to be accurately grounded in the data that produced it. This altered the names of theoretical codes and conceptual categories which resulted in theoretical sufficiency. I would now like to describe more in full the final resulting grounded theory.

Resulting Grounded Theory

The grounded theory is presented with the following structure. For clarity of reading, this section begins by defining terms which have a specific meaning as developed through the coding procedure. The grounded theory is presented in the following format:

- A table the lists the conceptual categories grouped by action, consequence or conditions.
- An integrative diagram to show how conceptual categories are related to each other and how they subsequently formed two core (super-ordinate) categories. The integrative diagram is accompanied by a narrative description of the emerging theory.
- Finally, each conceptual category is presented in table form (Tables 14-23) along with a brief narrative description. These tables show the construction process from open codes to focus codes that formed each conceptual category.

Terms used in the grounded theory. The terms *art maker* or *art viewer* are used to denote roles that were allocated to service users within the art therapy group by the art therapist at specific points in the video edited sequences. Art maker refers to the individual service user who was presenting the artwork they had made. All other service users in the group were thereby termed art-viewers in relationship to that particular art maker. These roles were not permanent, but their differentiation was a central feature of the social process highlighted by focus groups in the art therapy video edited sequences. In presenting the conceptual categories the terms *consequences* and *conditions* are grouped together because, as previously explained, the stepwise nature of the art therapist's intervention meant that a given action created a particular consequence, which itself then became a condition on which to base the next action.

Conceptual categories. The process of open coding led to focused codes, which resulted in ten categories; five categories refer to actions taken by art therapists and five categories refer to consequences and conditions in the art therapy groups (Table 12).

Table 12

Conceptual categories grouped by action, consequence or conditions.

Art Therapist Action	**Consequence/condition in Art Therapy Group**
Art therapist demonstrates engaged attention	Dismissive interactions between group members and with artworks
Insistence on an artwork focus	Structured group reflection around an artwork
Emphasis on commonality	Beneficial art-maker and art-viewer reciprocity
Art therapist devolves role	Reliable therapeutic interaction
Art therapist appears passive	Art therapist loses role

Conceptual categories were related as per the integrative diagram in (Figure 28), resulting in two core categories, namely: *Art therapist demonstrates attention* and *Art therapist appears passive*.

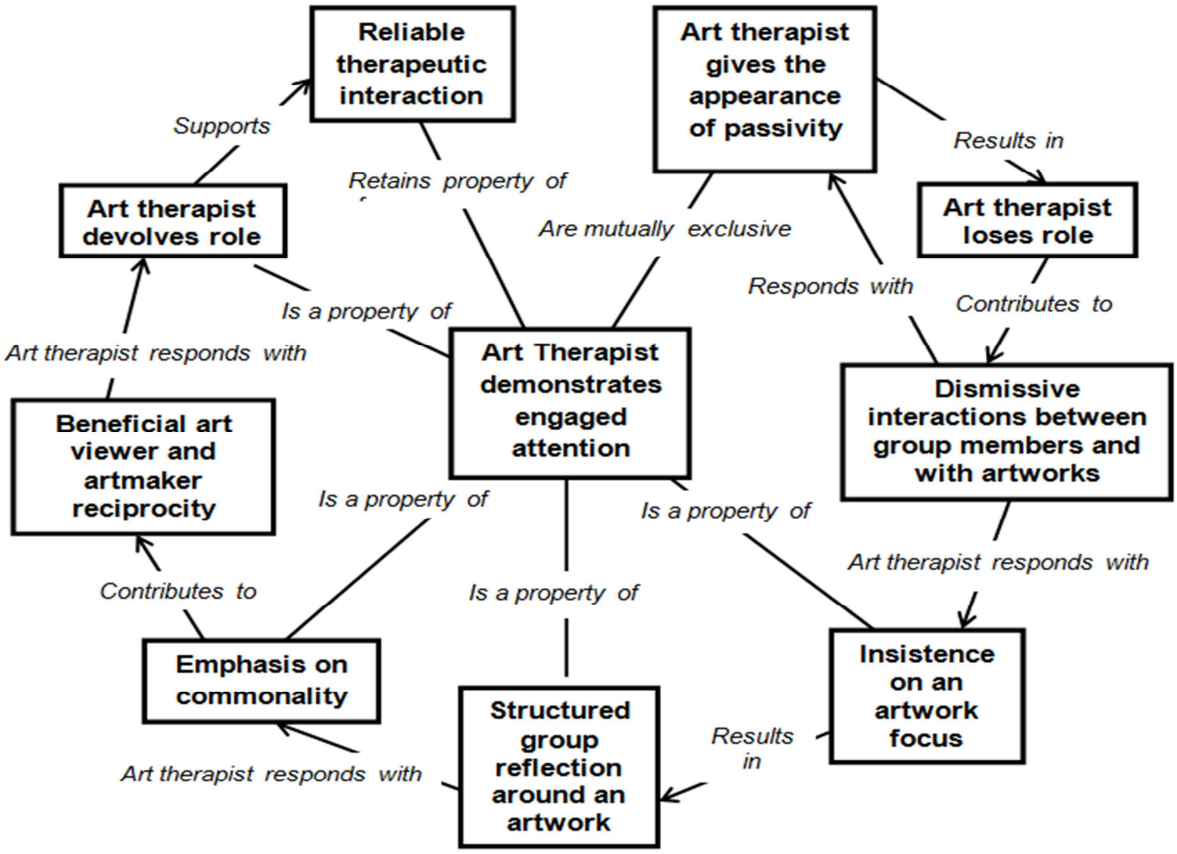

Figure 28. Final Integrative diagram indicating two core categories of: Art therapist demonstrates engaged attention; art therapist gives appearance of passivity.

The above diagram shows the relationship between two core conceptual categories of action. The diagram starts with dismissive interactions between group members and with artworks. The art therapist responded to that group condition in either one of the following two ways:

1. Whilst giving space for new phenomenon to happen in the group, the art therapist constantly demonstrated their emotionally engaged attention to the group. When the group started to show dismissive interactions between group members and with artworks, the art therapist responded with the following stepwise actions. First, the art therapist insisted that the whole group focus onto one artwork whilst simultaneously offering techniques to aid reflection. This resulted in structured group reflection because, depending on whose artwork was being focused on, each group member was assigned to

role of either art-maker or art-viewer and that viewing structure re-established the group's task as of the group as reflecting on that artwork. This had the effect of slowing down interaction in the group. Second, when the group slowed down to reflect on one artwork, the art therapists responded by emphasising the common elements between art-maker and art-viewer's artworks or verbalisations. Reflecting on the artwork from these respective roles contributed to reciprocal benefit between art-maker and art viewers. Third, once this benefit became apparent, the art therapist devolved their role of directing the focus of attention and offering reflective techniques to the group. This resulted in the sharing of the previous roles between group members and the art therapist. Where that role devolution supported a maturing therapeutic culture, defined by reflection and trust between members it was actively validated by the art therapist. All of these stepwise actions were delivered in the service of demonstrating the art therapist's interest and engagement in antagonistic interaction, and not as a means of controlling it.

2. Conversely, where the art therapist respond to dismissive interactions in the group by giving the appearance of passivity, by such means as not intervening, leaning back and being silent, it resulted in the art therapist losing the role of directing the focus and offering techniques for reflection. Where the art therapist lost their role it further contributed to dismissive interactions in the group and between the group and the art therapist.

I now wish to show the open and focused coding that constructed each conceptual category. These are now presented in table form followed by a brief explanatory description of the conceptual code (Tables 13 -22).

Table 13.

Dismissive interactions between group members and with artworks

Open Code	Focused Code	Conceptual Category
Art maker: saying I can't be with people not hearing other people's comments defensively holding ground against other views being hostile to attention fearing being misinterpreted struggling to stay in the group and room Suggesting art maker would be more upset later	Art maker becomes isolated from group group members	Dismissive interactions between group members and with artworks
Art maker: looking uncomfortable looking hard to just be constantly drinking from bottle experience not shifting being jumpy being loud to avoid feelings being unable to verbalize looking embarrassed and frustrated getting stuck in thinking not being able to name feelings producing a lonely image	Art maker being uncomfortable	
Art maker: indicates her artwork means nothing being irreverent to own picture verbal people only wrote words instead of making images not getting new insights into own artwork feeling forced to make art view of art not changing resisting seeing into art artwork being left unexplored having difficulty constructing a story from artwork saying his family would dismiss the group's art only using art to talk about something else	Art maker dismisses own artwork	
Artwork left at first impression and then ignored Group members: not interested in exploring artwork all treat art as superfluous not interacting with the art work rubbishing everyone's art judging all art therapy is not proper art	Group members dismiss artworks	

Group member: protecting themselves from others becoming more defensive withdrawing body language retaliating to a perceived attack withdrawing when upset referring to an earlier interpersonal problem during art-making stage of the group being scared so keep away setting off bombs and watching	Group members respond defensively to each other	Dismissive interactions between group members and with artworks *(continued)*
Group member: talking but not communicating volume in the room is overwhelming texting in the group leaving the room at inappropriate time only speaking about himself not changing approach to others getting gobby only coming to the group to unload	Individuals have little sense of impact on other	
Silent group members becoming more uncomfortable Only some group members speaking Group members: feeling without expression being uncomfortable feeling the group was not good enough battling for talking space finding it hard listening to others talk about shared feelings feeling group is unfair Focus is only on group members who talk about art	Reduced communication between group members increases discomfort	

This conceptual category describes a problematic state in the group that affects interpersonal relationships between group members, their artworks and to the therapeutic task. It causes great discomfort to service users and reduces reflection.

Table 14.

Art therapist demonstrates engaged attention

Open Code	Focused Code	Conceptual Category
Art therapist: having authority in attentive presence being emotionally present timing their transparent declarations being real being in the experience with patient soothes members helpfully pointing out disparity not empathising too much Everyone engaging in humour	Art therapist communicating their emotional presence	Art therapist demonstrates engaged attention
Art therapist: showing genuine curiosity saying I wonder what that is about repeating a patients question questioning an stated assumption not imposing meaning getting people to talk without influencing them demonstrating listening asks about an earlier point in group asking reflective questions asking for reflection but not control	Art therapist demonstrating their interest	
Art therapist: judging before responding balancing challenge and allowing watchful waiting observing presences making group-experimentation safe not using authority to clamp down looking for what is mentalizable encourages free speaking Suggesting all actions might be potentially creative	Art therapist giving space to emerging group phenomena	
Art therapist: noticing art viewers emotional reaction to image noticing art viewer's physical reaction to artwork seeming aware of non speaking group members using body to communicate engagement with whole group reacting differently to a debate and a fight in group	Art therapist indicates awareness of group member's reactions	

This category describes the action of demonstrating to the group that whilst the art therapist is giving space for new phenomena to occur in the group, they remain aware, curious and emotionally engaged with group member’s reactions,. The art therapist

demonstrated their interest through the use of body language, asking questions and transparency about their own emotional state. This was a core category because these features remained properties of the subsequent stepwise actions (Tables 16, 18, 20 & 21). This core category is mutually exclusive of the other core category named “art therapist appears passive”.

Table 15

Insistence on an artwork focus

Open Code	Focused Code	Conceptual Category
Art therapist: stopping a fight responding to something problematic in group responding to action overload noticing something new is happening handling a difficult situation engaging and steering group feels better choosing to speed up or slow down group activity becoming more forceful if content is inappropriate assessing what are we going to do with too much over-talking active mentalization stance looking different to old school psychotherapy	Art therapist active response to a difficulty in group	Insistence on an artwork focus
Art therapist: looking at artwork placing artwork on the floor placing artwork on a chair holding the artwork up	Art therapist non-verbally emphasises an artwork	
Art therapist: helping group member open up focusing group member on MBT dimensions encouraging naming feelings directs the focus to here and now connecting physical states and image linking physical with emotional suggests its useful to talk about not being able to think using questions to focus on feelings offering the chance to explore things in therapy that you can't outside not asking too many questions demonstrating a positive art-viewer role by offering different perspectives comparing group phenomena with external life Group member knowing safety in art therapist set boundaries Identifying different safety valves in art therapy for group members	Art Therapist offers techniques to help reflection	

Focusing on everything would bring chaos Art therapist: prioritising focus on art maker over other group members not responding to an earlier part of group not responding to all questions not reflecting on wider group interaction focus prioritising image over group dynamic choosing to attend to only one thing at a time Art focus excluding a focus on other things that happen in group	Art therapist prioritises their focus over other events in group	Insistence on an artwork focus *(continued)*
Art therapist: repeating a return to the art linking image back to the art-maker linking conversation back to artwork guiding focus onto artwork directing focus back to the art maker continues trying to find meaning in artwork connecting patient to their art by reiterating what they said and did in group bringing focus back to picture	Art therapist returns often to artwork focus	

This category represents a highly active response from the art therapist, which was often returned to when dismissive and problematic interactions in the group became difficult for group members. The art therapist emphasised one artwork, prioritising it over the many chaotic events in the group. In insisting on an artwork focus the art therapist explicitly offers techniques for reflection.

Table 16.

Structured group reflection around an artwork

Open code	Focused code	Conceptual Category
Presenting their art puts group member in a particular position as art-maker Art-viewer talking about the image meaning you are mind relating to that image Group spending time reflecting on here and now Shared responsibility to mentalize art and the group Referring back to task is to focus on artwork Group members bring relevant interpersonal difficulty to art therapy for reflection Finding meaning from artwork is the job of the group Art therapy task eliciting feeling responses in group members Art therapist managing the relationship between art maker and group	Reflecting task assigns group members to maker or viewer roles	Structured group reflection around an artwork
Artwork: is a concrete focus for group members providing a focus for the group viewing slows group member's interactions down focus keeping group interaction safe viewing is engaging for group members being like another group Group members: spending time on one artwork looking towards artwork needing a long time to talk about art being able to just observe interested in artwork because they just made it together needing multiple chances to explore art Everyone just looking at the image Art viewer reacting strongly to art maker's image Art therapist using image to keep own focus	Single artwork focuses the group's attention	

This category describes a condition where the group focuses around one artwork. This has the effect of slowing down problematic interactions, allocating group members to art-maker or art viewer roles and in so doing restating the therapeutic task.

Table 17.

Focus on commonality

Open Code	Focused Code	Conceptual Category
Art therapist: opening up other viewer perspectives on artwork inter-personalising everything moving to focus on group dynamic over exploring an artwork uses different perspectives as challenge testing art maker's assumption in group	Art therapist invites other group members to engage with artwork	Focus on commonality
Art therapist: linking image to group events continuing someone else's art theme through discussion using image to bring in other group members images suggesting art makers artwork is an image for the group sharing artwork content between people linking artworks together	Art therapist links artwork to the group	

This category describes how the art therapist widens the focus of the structured viewing of one artwork by the group by linking group members together through focusing on common features.

Table 18

Beneficial art-maker art-viewer reciprocity

Open Code	Focused Code	Conceptual Category
Art viewers: as having something to offer as therapy becoming freer to give views using expertise by experience peer to peer relating is therapy mirroring each other making effort for each other sharing inadequacies helpfully declaring their different minds complimenting group member Identifying the range of experience has value Equating therapy with better inter-group member relations	Art viewers more confidently offer own perspectives	Beneficial art-maker art viewer reciprocity
Art maker: image meaning widening through group empathy softening perception by sharing becoming more comfortable with empathy allowing herself to be thought about Equating therapy with art maker exploring with group	Art-maker getting new insights from others through their artwork	
Therapeutic change as art maker 'more in the room' Art maker: has pride in his artwork artwork becoming more alive in group expressing themselves lowers art makers anxiety exploring self through creativity celebrating in the face of challenge becomes strong enough for challenge	Art-maker valuing artwork as a representation of self in group	

This category describes a maturing condition in the art therapy group where art-makers and art-viewers each derive some benefit from their mutually interacting roles.

Table 19

Art therapist devolves role

Open Code	Focused Code	Conceptual Category
Group member: taking senior role providing therapy image to bring in other group members slowing the pace helping each other to speak directing focus to an artwork challenging each other is necessary linking discussion to here and now	Equating senior group member role and art therapist role	Art Therapist devolves role
Art therapist: validating reinforcing a therapeutic culture fostering a group led culture complimenting group member achievement being affirming	Art Therapists validates to reinforce autonomy	
Art therapist: and group members shifting roles around ceding control to group member letting the group have the power letting group decide direction balancing leadership between them and group Group members: not routing everything through the art therapist teaching art therapist Liking group member and therapist collaboration	Art therapist exchanging roles with the group	

This category describes how the art therapist reacts to benefit gained from more structured roles in the art therapy group. Where group members begin to interact reflectively, the art therapists cedes their role to group members. This results in a more fluid exchange of roles. The art therapist does not become passive, but actively validates reflective interactions and retains engaged attention.

Table 20.

Reliable therapeutic interaction

Open Code	Focused Code	Conceptual Category
Group members: independently reflecting challenging non-vindictively explicit mentalizing becoming implicit showing patience interest to each other Art being a presence but not dominating Identifying therapeutic change as group talking about each other's minds Supposing group members had had a lot of therapy	Group competently integrate roles and tasks	Reliable therapeutic interaction
Group members: feeling trusting each other over time feeling safe with art therapist seeing a bonded group Familiarity helping group members get down to stuff Art therapist: drawing on a therapeutic group culture and group members empathising together	Earned trust	

This category describes a highly mature set of therapeutic interactions in the group. These were based on trust between group members and the therapist and on the competency in interacting reflectively.

Table 21

Art therapist gives the appearance of passivity

Open Code	Focused Code	Core Conceptual Category
Art therapist: body language looking uncomfortable sitting back and saying "phew" sitting apart noting art therapist seems very different to group members	Art therapist's non-verbal communication of disengagement	Art therapist gives the appearance of passivity
Art therapist being too passive hanging back being problematic seeming emotionally absent not slowing down chain reaction not relating to what group member's said Feeling passive art therapist would be unsafe Everyone speaking except therapist	Art therapist passivity	

This category describes the second core conceptual category. It is essentially the reverse process of the proceeding stepwise approach in that the art therapist gave the group the appearance of passivity by not intervening in dismissive interactions in the group.

Table 22

Art therapist loses role

Open Code	Focused Code	Conceptual Category
No one noticing the therapist Group members: marginalising the therapy process ignoring the art therapist putting therapist out of role	Group members ignore the art therapist	Art therapist loses role
Art therapist: struggling to control group loosing voice fighting to get a word in getting caught in patients process	Art therapist loses control of group	
Suggesting when art therapist lets group get too full it loses significance Art therapist: confusing the patient not having a here and now focus not differentiating content and process in group discussion limiting pictures to only starting conversation adds new material to conversation	Art therapist confuses group members	

This category describes the outcome of giving the appearance of passivity, where the art therapist struggles to regain control but in doing so abandons the role of offering reflective techniques and instead adds their own content to the interaction. This then contributes to dismissive interactions in the group.

Having now described the conceptual categories, I would like to present the grounded theory at its highest level of abstraction, as a set of propositions. For clarity I re-present the integrative diagram (Figure 28) and then show the relationship between the conceptual categories as propositions.

Grounded Theory as Propositions

The integrative diagram showed the relationships between conceptual categories were as follows.

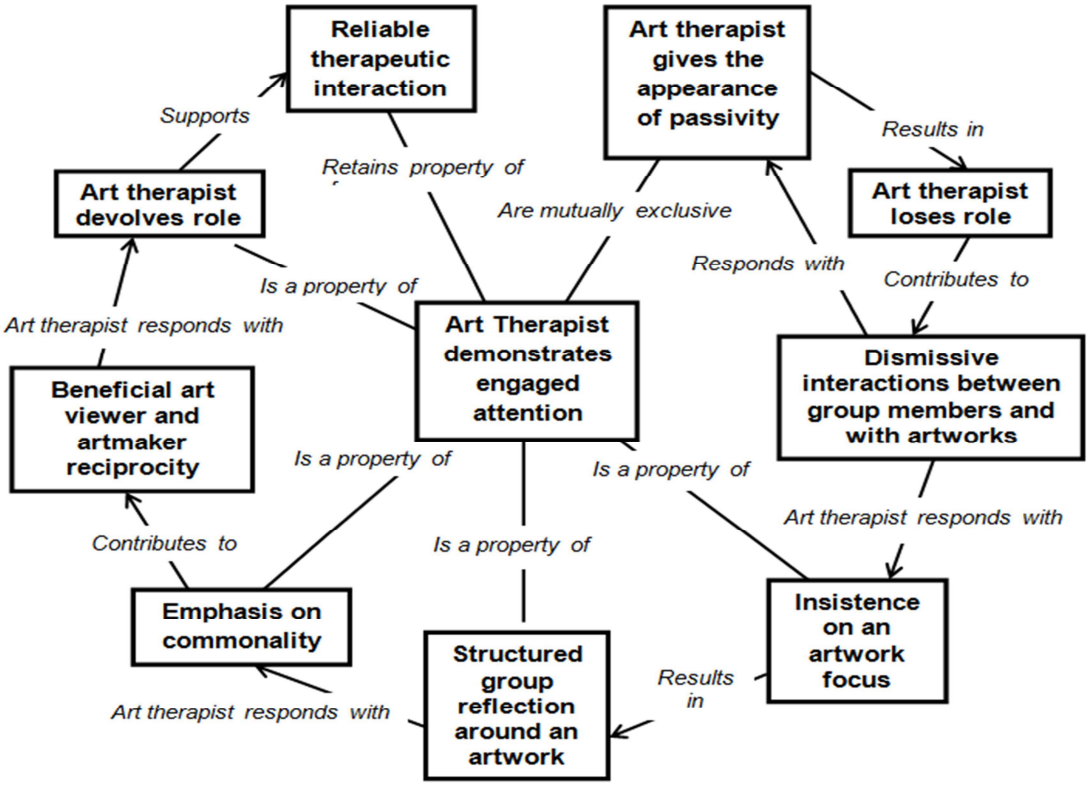

Figure 28. Integrative diagram (*which I use to form this table of propositions (below))*

The following table shows the conceptual categories and their theoretical codes as a set of propositions. These are presented in two sections, each relating to the core conceptual category which subsumed them.

Table 23

Interrelated conceptual categories with core category number one as a set of propositions

Core Conceptual Category One: Art Therapist Demonstrates Engaged Attention	
Interrelated conceptual categories	**Propositions**
Dismissive interactions between group members and with artworks ↓ **Art Therapist demonstrates engaged attention**	1. When responding actively to problematically dismissive interactions in the group, the art therapist explicitly draws the group's attention to how they are thinking group members and their artworks. 2. The art therapist directs group members' attention using both verbal and body-language indicators of their emotionally engaged attention. 3. The art therapist focuses on simple phenomena before attempting to focus on more complex issues. 4. It is not possible for the art therapist to demonstrate attention whilst being silent and showing passive body-language
Insistence on an artwork focus ↓ **Structured group reflection around an artwork**	5. The art therapist's first response to chaotic interactions in the group is to prioritise a focus one artwork over all other phenomena. 6. Group members show interest in the artworks they have just made. 7. When group members share a focus on one artwork it reduces problematic interactions 8. A focus on one artwork allocates each group member to either an art-viewer or art-maker role 9. when group members share a focus onto one artwork the art therapist explicitly offers techniques for reflection 10. It is a simpler task to reflect when group members are allocated to art-viewer or art maker roles.
Structured group reflection around an artwork ↓ **Emphasis on commonality**	11. Only when group members share a focus on a single artwork will the art therapist reflect on more elaborate links between group members and their artworks.
Emphasis on commonality ↓ **Beneficial art viewer and art-maker reciprocity**	12. Receiving empathetic art-viewer reflections on their artworks improves the art maker's confidence to engage with the group 13. Seeing that art-makers value art-viewers perspectives improves the art-viewers confidence to offer empathy to others

Beneficial art viewer and art-maker reciprocity ↓ Art therapist devolves role	14. The art therapist defers to group members when they demonstrate competence in the task of directing a reflective focus
Art therapist devolves role ↓ Reliable therapeutic interaction	15. Even when the art therapist devolves their directing reflective focus function and the group trust each other to jointly reflect, the art therapist continues to demonstrate their attention.

Table 24

Interrelated conceptual categories with core category number two as a set of propositions

Core Conceptual Category Two: Art Therapist Appears Passive	
Interrelated conceptual categories	**Propositions**
Dismissive interactions between group members and with artworks ↓ Art therapist gives the appearance of passivity	16. When the art therapist responds to problematic interaction in the group passively, they are silent and their body-language appears disengaged
Art therapist gives the appearance of passivity ↓ Art therapist loses role	17. An initial appearance of passivity when group interaction is problematic results in group member's progressively ignoring the art therapist
Art therapist loses role ↓ Dismissive interactions between group members and with artworks	18. Group members and art therapist find it harder to reflect as the group becomes more chaotic

Having now presented the findings, I wish to move to the discussion section in an attempt to stand back and reflect on the validity of processes which were used to develop the findings outlined above

Discussion

The hope in attempting practice-based research is that effort spent upfront in engaging with the complexity of naturalistic treatment situations will later yield greater compatibility for the application of those findings back to clinical practice. However, research in naturalistic settings necessarily involves pragmatic choices and that has implications for the validity of the findings the research produces. For this reason I have elected to focus here on the procedures I used before attending to the findings and their implications for art therapy theory in the conclusion chapter. I divide up the procedures into broad components for the purpose of this discussion section: First, the use of video edited sequences to represent art therapy; and second the use of diverse populations to observe them in focus groups. I now address each in turn.

Representing Art Therapy Practice: The Black Box

When Fonagy (2012) described the relationship between clinical practice and outcome research he employed a useful metaphor:"The evaluation studies are essential, but they will not succeed without some hypothesis about a better understanding of what is inside the "black box" of the therapeutic consultation" (p. 90). After the flight, the black box recording allows investigators to gain understanding about the journey. I hope it is not too pedantic to state that the black box is not the flight. It is a set of proxy measures and recorded representations and as such must justify its face validity in terms of what those who developed it intended it to represent as a construction. In the present study the black box consisted of three video edited segments of therapeutic action in a particular phase of MBT art therapy groups as chosen by the treating art therapists. I wish to consider the face validity of these representations of art therapy practice.

Can art therapy be recorded? The primary face validity question was how art therapy may have been altered by introducing a black box into treatment as usual. The

feasibility study had demonstrated that it was technically possible to represent enough interaction within a group art therapy setting using a fixed position camera for focus groups to produce analysable data. However, this had not involved clinical art therapy sessions and so did not encounter the issues of how recording might affect the delivery of art therapy as usual. In other words, would what was recorded still be art therapy in a clinical setting?

At the start of the study I found many art therapists were interested in observation but felt concerned about its effect on the therapy they delivered. However, few could describe what effect recording might have. A number of art therapists told me that they had been advised during their training that observation of art therapy was inappropriate. Where objections were cited in the literature, the concern was that opening up the confidentiality between therapist and service user would fundamentally damage the transference relationship (Dolphin, Byers, Goldsmith and Jones, 2014; Dudley, 2004; Schaverien, 1995). However, my observation was that the paralysing effect of anxiety about recording was disproportionate to the small amount of literature that cautioned against it. Feeling it would be damaging appeared to be more powerful in influencing art therapist attitudes than published literature. I found it was essential to create professional spaces to open that debate up, to look at the evidence and speak explicitly about those concerns. I detail the discussion forums I constructed in Appendix A. I drew on the literature review to introduce an alternative hypothesis about professionals concern for absolute confidentiality, namely that research had indicated that therapists could attribute their own anxiety about having their performance viewed by peers to concern for service user confidentiality (Gill et al., 1969; Shepherd at al., 2009). Interestingly the feedback I received at these events was that art therapists found their opinion changing more because I showed a video of my own practice (for which I had consent) than any reasoned

argument. This rather confirmed the idea that it is what happens socially between professionals which can determine how theory gets constructed.

Whilst addressing professionals' anxiety gained me volunteers to submit videos, the question still remained about whether service users would object to being recorded. Through the course of the present study, I spoke to service users in my own site and visited and discussed the research with the clinical team and service users in one other site to discuss consent to observation. All service users consented apart from one. However, at the third site all service users consented but the treating art therapist's staff team objected. I was unable to meet the team and it resulted in a 12 month delay in obtaining video edited sequences. The situation resolved when staff, who were all psychodynamically orientated, undertook training in the MBT model.

My reflections on this phase of the research very much echo Bateman (2007) who referred to a powerful dynamic where clinicians often feel they know "their" service users' wishes and so make decisions which affect research on their behalf. It has been suggested this is particularly so in psychodynamic models which imply the professional has some privileged access to the unconscious of the service user (Karterund & Bateman, 2013). The team that objected to observation conformed to the idea that staff, particularly psychodynamically orientated practitioners, can attribute their own anxiety about observation to service users. This was important because art therapy had been so dominated by psychodynamic theory in the last three decades (Edwards, 2004; Karkou & Sanderson, 2006) that this was likely to have contributed significantly to the fact that art therapy has lagged behind other professions in using observational methodology. That service users, clinical teams and art therapists did consent, when the literature and aspects of professional culture suggested they would not, goes some way to supporting the validity of the video edited sequences: It was possible to record art therapy groups. It does

not answer how those groups may have been affected and I would like to consider this now.

How might recording affect art therapy as usual? This question was raised a number of times in the observing focus groups. The treating art therapist colleagues and I agreed a clinical approach taken to the introduction of video cameras into clinical practice (outlined in the methodology chapter). In considering how representative recorded art therapy had remained I followed the approach described used by Gill et al., (1969) This involved asking the treating art therapists to self-rate whether they were practising as usual with the video camera present. I chose a self-rating methodology because, as Gill et al., (1969) had reasoned, the criticisms that observational methodology distorts therapy had originated from a self-rating approach and therefore it was logical to use the same method to assess the effect.

In the art therapy group I was involved with, the video camera had been introduced for the purpose of clinical supervision prior to the present study, and not specifically for the research. When I asked for consent it was to extend the range of viewers of the videos to include focus group researchers and everyone in the group consented. I noticed no difference in the way that service users were in the group after they gave consent. Attendance was consistent and the only comments about the video camera after this was point was when it fell over and the service users joked that it was a pity because that was a good session. I did find that the idea of a new range of viewers made me much more self-conscious at first and I suspect that altered my approach for a time. However, I soon became used to the idea and I chose a video edited segment some six weeks after changing the level of consent and that practice seemed no different from usual.

My two treating art therapist colleagues introduced the video camera specifically for the research project. They selected their video edited sequence from a later point in

videoing, when the group had become more accustomed to its presence. Their experience was that service users rarely mentioned the video but described their own feelings of anxiety being high at the start. One told me that on the first day of videoing, group members asked him why he was suddenly asking so many questions. He realised he had become so anxious to be seen to be on the MBT model for video that he had gone "off model". Such anxieties initially created distortions in the therapists' activity more than in group members, but they settled after a few weeks. Both treating art therapists felt the video edited sequences they eventually offered were representative of practice. Again, this very much conforms to the experience Gill and his colleagues reported.

Art therapist opacity. Another objection to using video was highlighted by Patterson et al., (2011) whose interviews with at therapists revealed a fear that observation would not detect their internal work in the sessions, such as monitoring counter-transference. Having had my practice both videoed and then reviewed by focus groups, I feel well placed to now comment on how much the art therapists subjective experience can be picked up through observation. When transcribing audio data from the focus groups I was deeply impressed by the accuracy of their description of my feelings and thoughts in the session. Indeed, on reviewing the video edited segments all three treating art therapist were unanimous that it was our transparency that made being videoed so uncomfortable.

My lack of opacity was revealed to me through a rather unnerving experience in this respect. It bears retelling here because it confronted me with just how unwittingly the therapist discloses even core personal issues in therapy. In the following extract the Emergence focus group made an aside about the way I had laid out the art therapy room (see Figure 14 for room layout). Art materials were stored behind me in a tambour unit, which are the same units typically used to store stationary. The focus group commented on my use of the environment:

Focus group participant D: "I have to say I was really struck by the fact it felt like they were exploring a massive issue in a stationary cupboard

(All laugh)

Focus group participant B: "NHS care!"

Focus group participant A: "It's a bit claustrophobic!"

Focus group participant D: "It had a profound effect actually ... am I being emotionally held or am I being stuffed amongst the post it notes (laughs)"

I absolutely have to own this as a trait. I grew up in a chaotic household and have a real blind spot about environments. I often notice how other art therapists make their studios more conducive to therapy than I can manage. The observers had seen *me*. Similar comments were made in the treating art therapists' focus group about seeing their own personal issues disclosed. In stating this I do not wish to imply that the use of video reveals the complete inner working of the art therapist. I merely suggest that claims that nothing about the art therapists internal or personal reactions, including processing counter-transference, can be subject to observation has some doubt cast upon it by these experiences and is arguably overstated as an objection to such research.

Summary Face Validity of Video Edited Sequences

Whilst acknowledging McNiff's (1995) point that video may never fully capture the experience of art therapy, I found video edited sequences with photographic representations were rated by the treating art therapists as representing a great deal of what they did in therapy as usual. No service user rating of validity was attempted for ethical reasons as viewing video of therapy could be upsetting. This was a limitation as it would be highly valuable to estimating face validity to have service user feedback on video edited sequences. Many of the barriers to developing a "black box" for art therapy were not technological or therapeutic but attitudinal. I found where professionals objected to

observation it was predominantly on behalf of service users rather than directly from service user themselves. This seemed to be best addressed by showing video edited sequences of my own approach.

Having discussed the process of gaining video edited sequences I should like to consider the next stage of the process which was the use of observers to describe what they saw on those video.

Broadening the range of observers of art therapy. Goldfried, Raue and Casteguay (1998) asked how a 'fly on the wall' would describe what therapists did in practice. Social constructionist epistemology raised an important question: Perhaps it depends on the fly? The literature review had suggested that service users tended to evaluate therapy more on its emotional tone than professionals (Perren, Godfrey and Rowland, 2009; Janzen, Fitzpatrick, & Drapeau, 2008) and that their views often were better predictors of a successful therapeutic alliance (Horvath and Bedi, 2002; Horvath and Symonds, 1991). I certainly found that emotional tone was very quickly foregrounded by the Emergence group and that this became a key element in the resulting grounded theory. I found the psychological therapists surprisingly silent on this point. Their concern was more with technical aspects of the therapy, making useful comparisons between art therapy approaches and verbal groups. The art therapists spoke a great deal about the emotional tone of the video edited sequences. They offered useful observations about the relationship of the art-maker to their artwork and to the rest of the group. I was involved in the treating art therapist focus group. We all described valuing the discussion of our work, and remarked just how much we had forgotten about what had occurred in the group. This supports the validity of the social constructionist imperative to not just ask what the basic social process is, but to also question what is "basic to whom" (Charmaz, 2006, p. 14). This therefore rather undermines the notion that the therapist can act as the sole witness to

the therapy as implied by the reliance of self-reported case study method as a theory building tool in art therapy (Gilroy, 1995).

In the present study I obtained different perspectives by using a mixing quota sampling with theoretical sampling as described in the methodology chapter. I achieved quota sampling by having internally homogenous focus groups which were heterogeneous to each other. I maintained the use of the interview schedule in each focus group before asking theoretical sampling questions so as to gain that population's particular perspectives before introducing ideas from other groups. This method seemed to be very useful in building the range of views. It had implications for the grounded theory method used though, particularly with respect to theoretical sampling within limited data. I found grounded theory highly flexible whilst retaining the key features of the approach. After quota sampling via focus groups had finished, I found the process of memo writing and theoretical sampling revealed significant patterns which I simply could not see prior to undertaking the analysis. I maintain that it was vital to allow each new focus group to give its first impressions before asking theoretical sampling questions as this created the breadth of opinion.

Within the focus group populations, the use of service users as observers of in vivo art therapy practice was one of the more innovative and perhaps radical decisions taken in the study and I should like to give some attention to that.

Service user focus groups. The inclusion of service users as research observers had not been attempted before in art therapy. I had concerns about the demands this would place on potentially vulnerable individuals, concerns which were echoed in the research ethics committee. The use of a well established service user organisation such as Emergence was essential assessing the readiness of participants to undertake the research. I felt Emergence provided the right balance of an independent service user perspective, not

overly controlled by professional norms yet providing essential support. It was vital that the service users had the condition being studied. In my feasibility study the ResearchNet group did not share a condition and they commented that their contribution might be limited if they had not lived the experience of the diagnosis of BPD.

When I visited research sites, the service users being treated in the art therapy wanted to join the focus groups. In research terms this would have been a very powerful way of gaining perspectives of service users on their own treatment. Yet the process of observing video edited sequences could be demanding and potentially destabilising. In the absence of examples of service user involvement in this type of research I was not able at this point to construct an ethical justification to use participants for this purpose. A cautionary example occurred once when in the Emergence group found video edited sequence number three particularly emotionally powerful. The transcript of this is presented with my reflection in the research diary (Appendix A). To summarise, the service user felt "zoned out" because they painfully identified with an issue the service user had described on the video edited sequence. It is of note for the core conceptual categories that what triggered her was a sense that the art therapist was disengaged. This example says something about the power of the appearance of passivity or distance in the therapist.

It is clear then that service user observation procedure was not without some risk, but mitigations of that risk were possible. It was important that the focus group moderator had clinical skills in working with people with a diagnosis of BPD. It was also important that service users were within a known and supportive structure as provided by Emergence. We had negotiated many of these structures beforehand, as represented in the research diary, and they were needed. The focus group also showed high levels of empathy for each other in the session which helped enormously. As the group continued, participant B was in fact

able to contribute and joined in actively throughout, as did the rest of the group. At the end of this session all focus group participants said that whilst it had been draining the experience was "enjoyable" and "rich". In subsequent contact with the Emergence research director, I was informed that everyone had valued the research process including participant B. She told me that their researchers do get triggered by the work they undertake, as they do from other events in life, but are passionate that the service user voice should not be excluded because of that. I do not believe my findings would have the richness and validity without the involvement of service users. They identified key components of the theory. But I do not think that this research would have been ethically justifiable without the support provided by a host service user organisation and the clinical skill of the focus group moderator.

Gaining a range of views was vital in building a multi-perspective description of the video edited sequences. The service user perspective was the most novel in art therapy and whilst it presented challenges, these were not so great that they justified exclusion from theory building. The value of co-production research had been described as not only capturing consensus but also differences of perspective (Gillard et al., 2011). However, in capturing differences between observers, the question of reconcilability of those differences was raised. In the present study, most differences between focus groups tended to add an understanding to the observations made by others. For example service users added the emotional quality to the procedural observations made by professionals. But one area where the differences seemed irreconcilable might be between the self-rating of the treating art therapists and the way observers disputed whether that practice was indeed therapeutic. I should like to discuss this important issue now.

Self-rating versus observer-rating. As the findings section describes, video edited sequence two was rated negatively, in some cases as un-therapeutic, by focus groups.

Observers differentiated it from the other two video edited sequences. They identified that the artwork was ignored by the art therapist and the group. Even after it was explained in the treating art therapists' focus group, I struggled to see how this video represented therapeutic practice asked for in the research study information sheet. How can the disparity between the way the art therapist self-rated their video edited sequence and the way the focus groups rated the same be understood?

A number of explanations might apply. Perhaps the focus groups were not able to detect the actions the art therapist claimed to undertake or the consequences that ensued. This argument is hard to sustain given the negative perception represented the strongest level of consensus amongst a heterogeneous set of focus groups which at no point met. On numbers alone, it was in effect a fifteen to one perspective. Another explanation may be that the outstanding rating indicated a flaw in the study's sample gathering strategy in gaining an homogenous sample of video edited sequences which showed therapeutic actions in the triangular relationship. But given the aim of sampling was to a range of art therapists' perspectives on what therapeutic action looked like, the information sheet was more liable to be problematic if it were to become too clear and therefore prescriptive. I have to conclude that, just as in video edited sequence one which had the same sampling approach, video edited sequence two represented how that fully qualified MBT trained art therapist selected to show how they interacted with service users and their artworks in a groups setting for people with borderline personality disorder, whether or not anyone else agreed.

I think the self-selection of case material by therapists was an important part of the research and deserves some reflection. As the literature review showed, art therapists built theory narrowly by identifying therapeutic processes within their own practice, creating case narratives to represent that practice and then linking that case narrative to existing

theory. The present study preserved a primary aspect of this process in that it was the art therapist who selected an example of therapeutic process. After this point the theory building approach processes was altered. Practice was not represented by a self-reported text but by a video edited sequence with artworks involved. Instead of self-reporting the study asked *others* to develop the narrative of practice in focus groups. Finally, instead of linking to existing theory a grounded theory approach was taken. The findings appear to contradict the therapist self-rating in video edited sequence two. The likeliest explanation appears to be that discrepancy between the art therapist attributions of what constitutes therapeutic action and the attributions made by focus groups may illustrate the limitations of self-report as a strategy for understanding therapy. The literature offered confirmation of this in numerous examples of how difficult it was for therapists to make sense of therapy purely through therapists' self reports (Greenberg, 1991, 1993; Alpert, 1996).

Yet, far from being problematic in the present study, the disparity of ratings proved to be central in helping to build a grounded theory. It was opportunistically fortunate to have a markedly different set of actions and consequences represented. One of the considerations for the next stage of observational research would be to sample for contrast by asking for both therapeutic practice and "off-model" art therapy examples. I do wonder what it would be like to ask therapists to show the less good practice and whether that approach would yield any sample at all.

Summary of research process. Including a range of observers yielded different perspectives on the video edited sequences. In doing so the study greatly extended the self-report methodology typically used by art therapist to build theory. The range of viewpoints was captured via a quota sampling approach which had implications for the grounded theory analysis. Many grounded theorists have modified the original Glaser & Strauss (1967) approach and some now claim it can no longer be described as a single unitary

approach (Charmaz, 2006; Dey, 1999; Urquhart, 2013). Yet the essential principles of the method yielded insights from the data which, as I will discuss next, greatly added to art therapy theory.

Having discussed the procedures used in the research, I should now like to move to the conclusion chapter where the findings can be explored in relation to existing theory.

Chapter Seven: Conclusion

This study sought to understand the way that art therapists interacted with people and their artworks in a mentalization-based art therapy groups aimed at treating people diagnosed with personality disorder. The literature review revealed that the description of practice had been neglected in art therapy. Observation of clinical practice produced a grounded theory of art therapist action and consequences. The following chapter is an attempt to make sense of those findings in the context of existing theory, practice and research. I begin by stating my thesis and describing the empirical evidence accumulated to support it. I then consider the implications for theory, practice and future research and reflect on how the study affected my epistemology. I finish the chapter by describing the strengths and limitations of the approach taken and offer a summary.

Thesis statement. Based on the findings of the present study I conclude the following:

> Those people diagnosed with borderline personality disorder who begin group therapy often appear profoundly uncomfortable in that setting. Such therapy groups can quickly become chaotic, with people becoming multiply dismissive of themselves, other group members, artworks and the task of the group. In mentalization-based approach art therapists structure their groups to respond to these difficulties. Group members are asked to make artworks prior to bringing them into an interactive and discussion-based meeting. Group members take turns in presenting their artworks to the whole group for discussion. Should the group interactions become chaotic the art therapist intervenes quickly: instead of engaging with other phenomena in the group, they prioritise creating a shared focus on the artwork that was due for discussion. The art therapist does so by insistently highlighting his/her own interest about that artwork. That focus is simplified

concentrate on the art-maker's intention in making an artwork. Shared attention around an artwork can create a pause in the group. It appears to draw on key points of valence: group members have high interested in the artwork they each have just made and as material objects, artworks provide an accessible target for a group to share focus upon. Only when many group members share a focus does the art therapist move to more complex explorations. When group members become more able to share reflective attention autonomously, the art therapist's active input can reduce although continuous of emotional involvement in the group is signaled. There is then, a direct relationship between the art therapist demonstrating their attention and coherence in the art therapy group.

Empirical basis for the thesis. The above thesis statement is based on a range of observers of clinical art therapy sessions. Central to its construction was how my grounded theory analysis of their observations had resulted in two core conceptual categories of "art therapist demonstrates engaged attention" and "art therapist appears passive." These two categories were mutually exclusive responses to group phenomena entitled "dismissive interactions between group members and with artworks." The relationship between these two core categories, their respective subordinate conceptual categories and the group phenomena they were responses to is outline below (Table 25).

Table 25

The relationship between core conceptual categories and their subordinate conceptual categories

Core Conceptual Categories	**Art therapist demonstrates engaged attention**	**Art therapist appears passive**
Conceptual categories specific to each core conceptual category	Insistence on an artwork focus Structured group reflection around an artwork Emphasis on commonality Beneficial art-viewer and art-maker reciprocity Art therapist devolves role Reliable therapeutic interaction	Art therapist loses role
Common Conceptual Category	Dismissive interactions between group members and with artworks	

An examination of the distribution of conceptual categories that formed the two core conceptual categories (Table 25) immediately reveals two distinct features which have relevance for existing theory in art therapy. Firstly, there was an imbalance of subordinate conceptual categories between each core conceptual category. This was because the art therapist demonstrated their engaged attention through a stepwise action and the conceptual categories detail that process. Secondly, both core conceptual categories share a common subordinate conceptual category entitled "dismissive interactions between group members and with artworks." This was because that category describes the condition of the art therapy group that both conceptual categories were responses to.

I now aim to use table 25 as a structure to consider in-depth how the findings link to existing theory. I begin with the common conceptual category of "dismissive interactions between group members and with artworks" as cited at the base of this table because I believe the art therapist's actions only make sense when considered in the context of the group's condition. This also reflects Kazdin's (2004) reasoning that therapeutic action

should be considered in relation to the difficulties those diagnosed with a particular condition. I then address the top level of results, the core conceptual categories, and relate them to the research question. This is followed by a more detailed exploration of the conceptual categories which constituted the core conceptual categories.

Theoretical Implications

The theoretical implications of the findings impinge on a great deal of art therapy theory. In order to examine that my consideration of each category requires detailed cross-referencing with points I have raised from the literature review in chapter two to four. I include references to literature as I explore each conceptual category in turn.

"**Dismissive Interactions between Group Members and with Artworks.**" This conceptual category describes what focus groups observed when people who have been diagnosed with borderline personality disorder are brought together with an art therapist to discuss the artworks they have made in relation to their personal difficulties. It represents a difficult and painful condition that the art therapy groups tended to both start with and periodically succumb to again. Observations of service user behaviours in that group condition conformed closely with interpersonal problems described in the literature for borderline personality disorder. For example, where groups were chaotic and they showed what can be described as declining levels of mentalization amongst members. This created a vicious circle where the group quickly became hostile and stressful which added further threats to mentalization. The features of the relationships conformed closely to the concept of "mind-blindness", a term originally used to describe autistic traits but adopted to define the antitheses of mentalizing (Allen, Fonagy & Bateman, 2006, p. 41; Table 2). Specific examples of this were when groups members acted without any sense of potential impact on other people, such as texting on a mobile phone when someone was expressing distress. At other points group members described an extreme sense that they felt judged or

threatened and observers noticed that group members looked "hard to be in themselves," sometimes having to leave the group temporarily because their anxiety was so high. Reduced mentalizing was apparent in relation to artworks. Observers noted that service users had powerful, seemingly physical, reactions to artworks. On other occasions service users used the artwork negatively towards themselves and others, describing it as worthless.

Service user research in art therapy has highlighted that the art in art therapy can easily compound feelings of failure and worthlessness for people with borderline personality disorder if not addressed actively (Morgan, Knight, Bagwash & Thomson, 2012). The experiences in these groups did not show evidence of the artwork acting as a buffer for hostile feelings as had been described in the literature on the triangular relationship (Case, 1990; Schaverien, 1990). Rather, it confirms to the notion that art-making or art-viewing is not inherently safe for people with borderline personality disorder and the task of therapy is to make it so (Greenwood, 2001).

In many ways, observer descriptions of this group condition epitomise the defining features of what the construct of borderline personality disorder seeks to describe. The art therapist could not assume that a baseline pre-existed whereby group members would know how to cooperate or manage the feelings that come with being in proximity with others, as they might with other populations. The groups depicted in the video edited sequences offered what Karterud and Bateman (2012) described as the opportunity to attempt deliberate mentalization under the very pressures of a complex interpersonal context that normally reduces mentalization. What is clear is that mentalization-based groups for people diagnosed with borderline personality disorder are highly challenging for service users and for therapists alike. With that in mind I now wish to give attention to

how art therapists respond to this condition as represented by the two core conceptual categories.

Core Conceptual Categories and the Research Question

Core conceptual categories represent theory at its highest level of abstraction (Urquhart, 2013). If this level of abstraction were applied to the whole study it could be summarised as follows. I wanted to know, how art therapists interact with service users and their visual artworks during the discussion section of mentalization-based art therapy groups aimed at treating people with personality disorder? After sixteen participants in four separate focus groups observed three fifteen minute video edited sequences of *in vivo* art therapy groups for people with borderline personality disorder, the answer was that the art therapist either demonstrates engaged attention or they give the appearance of passivity.

Taken at this level, one feature of the resulting theory becomes immediately apparent. Whilst the research question was concerned with how art therapists interact with service users and their artworks, neither core conceptual category refers to art. Instead both "art therapist demonstrates engaged attention" and "art therapist appears passive" describes the emotional tone of the relational stance of the art therapist. It could be argued that taken in isolation, these two core conceptual categories might apply to any type of psychological therapy. I was surprised by this result because I had anticipated some art therapy specific action to be a core conceptual category and would now like to consider how that finding might be understood. A compelling idea is that this result lends weight to Frank's (1961) prediction that psychological therapies have more in common than separates them. The commonality he predicted has received acceptance at high levels in mental health policy. The UK Department of Health produced public guidance called

"Choosing talking therapies" which captured the principle that the emotional tone of the relationship takes precedent over consideration of the type of therapy:

> "A particular therapy might work for you even if there is no evidence yet, to back it up. What seems to matter most is your relationship with the therapist; if you feel you can trust and work well with them, it is more likely to help you." (Department of Health, 2001, p. 2).

The guidance also cites a service user's description of the effect of therapists appearing passive: “I had a year with a psychotherapist. Her distance was very damaging to me and felt like torture when I was in high distress.” (Department of Health, 2001, p. 8). In presenting this I am aware that present government thinking around increasing access to psychological therapies has tended to favour the notion of evidenced-based therapies over therapist competency or stance. As was stated in the epistemology, there is an argument that some mental health practices are more suited to the RCT methodology that support the evidence based paradigm. I present the Department of Health guidance "Choosing talking therapies" because it represents an alternative discourse that the interpersonal style of the therapist is as least as important as their school of therapy (Henry, Strupp & Butler, 1993; Strupp and Anderson, 1997).

Similarly the relational, rather than art nature of the core conceptual categories would support claims that mentalizing was a common, non-specific mechanism that underlies all psychological therapy (Bateman and Fonagy, 2006, 2012). The literature was illuminating on why the tone of the relationship should be central to developing metalization, particularly in the need for the service user to find themselves in the mind of the therapist (Bateman & Fonagy, 2006). Allen (2013) suggested that mentalization was a common feature because it utilises the mirroring-based neurobiological structures of the attachment system as its mechanism of change. Many mentalization authors referred to the

role neurobiology of attachment in affect regulation: “The brain’s first and most powerful approach to affect regulation is via social proximity and interaction.” (Coan, 2008, p. 255). Fonagy summarised that nature has tasked attachment with the role of developing the interpersonal skills to share attention mental states (Fonagy &, Luyten, 2009). If attachment is damaged, as evidence suggests it is in many who become diagnosed with borderline personality disorder (Zanarinni, 1999), then this precludes the sufferer from the mechanism they need to mentalize and thereby affect regulate. Therefore, remodeling the interpersonal or attachment style of the sufferer would be the first task of any therapy attempting to help the service user reflect with the therapist on mental states and increase mentalization (Allen, 2013). In this sense mind-blindness must be overcome by through shared attention on mind-focused exploration of artworks. As Fonagy observed at the British Association of Art Therapists' Attachment and the Arts conference in 2010, there may be many therapies but only one brain (Figure 4). Perhaps it is less surprising then, that the core conceptual categories indicate *what* the art therapists' actions aimed to do. They shared a common purpose with other therapists who aim to support mentalization as a first principle in therapy. *How* that is done is represented at a lower level of abstraction, and at that level details about interaction with art are revealed.

The key to the core conceptual categories is that they relate to the signalling of one person's attention (the art therapist) to another (the art-maker) or others plural (service users in the group). The mentalizing model puts great emphasis on ostensive affect communication through contingent and marked mirroring, as identified in studies of early attachment, as the primary means activating the attachment system in psychological therapy (Fonagy, Gergely, Jurist, & Target, 2004; Gergely, 2007). The assumption is that active contingent and marked mirroring is the means whereby humans signal the presence of their minds and the focus of their attention to each other. In the still face experiment the

infant reacts catastrophically to social signalling being deactivated when the mother stops responding with her face. When she starts signalling her own responses to the child, the child quickly becomes re-organised (Tronick et al., 1975). In the false cliff experiment the mother's facial expression determined whether the child continued or halted in their exploration of an uncertain situation (Sorce, Emde, Campos, & Klinnert, 1985). Signalling intention is therefore the means to address mind-blindness. It seems highly improbable that the art therapist would somehow not be obliged to use the mechanisms gifted by nature or be operating in some new and special manner completely distinct from other therapists.

Given ostensive communication was so central, it is of note that the two core categories were in a mutually exclusive relationship. The dimensions of that relationship were whether the art therapist signalled their engagement or not. Given these two actions were responses to dismissive and distressed interactions in the group, they might be summarised as leaning in or backing away. Each would confer a powerful meaning to the service user about what they were experiencing, as either interesting or repulsive. It was hard to detect how art therapists approached their engagement with service users from the literature. Whether they leaned in, actively attempting to engage, or whether they sat back, attending inwardly to their counter-transference was not clear in the way art therapists write. The more recent art therapy literature on art therapy for personality disorder tends to towards the idea that the therapist must demonstrate attention. The art therapy professional consensus guidelines for borderline personality disorder gave this particular emphasis in stating: "The art therapist offers their genuine responses to artwork and events in therapy in the service of therapeutic communication." (Springham, Dunne, Noyse & Swearigen, 2012, p. 134). This conforms to the MBT model (Appendix B). The art therapist's attention, as a mind-based phenomenon in the group, would not easily be detected or

inferred by the service user if they were entering a mind-blind state. That task becomes far harder when the therapist appears passive because the mind is not signalled.

The mutually exclusive relationship between these two core conceptual categories closely conforms to the differentiation Karterud and Bateman (2012) drew between mentalization groups and analytic group styles. In this Karterud and Bateman described the analytic group therapist observing but rarely intervening and leaving issues to the group to work on themselves. In the mentalizing group the therapist intervenes, frequently asks the group to stop, rewind and reflect. A passive therapist cannot be described as working within the mentalization model.

Objections to common mechanisms in art therapy. A strand of literature in art therapy raised objections to the notion of common mechanisms in art therapy. In reviewing what works for whom (Roth & Fonagy, 1995), Jones (1996) specifically highlighted that the notion of common mechanisms of change might be threatening to art therapy when it was seeking stage regulation and acceptance as a therapy offering unique benefits. More latterly art therapists have sought to identify unique features of art therapy through neuroscience. Most of the claims to uniqueness have emphasised the physical making aspect of art therapy, particularly the relationship of the hand to the brain (Hass-Cohen, 2008, Elbrecht, 2013). These are no doubt a unique features, but it is possible to criticise that claim on the basis of the relational aspects of neuroscience as they relate to art therapy, perhaps most powerfully in the discussion phases of sessions, has been neglected (Springham, Thorne, & Brooker, 2013). Without that relational aspect, many of the benefits inferred from neuroscience would pertain to any art and health practitioner. Case (1990) suggested the art therapy triangular relationship may be a key to differentiating art therapy from what might now be called arts and health. In doing so she inferred the superiority of the relational aspects of art therapy above the therapeutic

benefits from making art as a defining feature. The fact that the core conceptual categories in the present study have similarly positioned the relationship as central to that differentiation supports her claim. My reading is that art therapy has unique features in combining art making and relational aspects, but each respective aspect has more in common with the neighbouring fields of psychological therapy or arts and health than separates it. That said, the allocating of specific actions in relation to the art as servicing an overarching relational aim is an elegant formulation of the triangular relationship. It has had the effect of clarifying the therapeutic purpose and removes a false dichotomy that one either attends to the service user or the art. As the aesthetic theorist Nicholas Bourriaud suggested: "Art is a state of encounter" (Bourriaud, 2002, p. 18).

Having explored the two core conceptual categories, it would be useful to discuss the conceptual categories beneath them as they contain important descriptions which allude to more art therapy specific phenomena.

Conceptual Category One: "Art Therapist Demonstrates Engaged Attention"

Having highlighted that the grounded theory's two core conceptual categories may be construed as non-specific or common mechanisms, I wish to restate that the research question was an attempt to detect unique features of art therapy in the mentalization model. It was at the subordinate level of conceptual categories that the art therapy specific actions, describing what the art therapist did in the triangular relationship, were identified. This level highlights important detail about mentalizing in art therapy in the sense of using different approaches to those described in the verbal model. I therefore wish to address the actions at conceptual category level now, examining how each stepwise action does or does not conform to the literature either in art therapy or MBT. I start with those that relate to the core conceptual category entitled "art therapist demonstrates engaged attention" and then move onto the same in "art therapist gives appearance of passivity."

"Insistence on an artwork focus" as a property of "art therapist demonstrates engaged attention." The groups featured in the video edited sequences all used a turn-taking approach. This model had been contrasted to the group analytic art therapy approach which lets the group decide when or if art works were to be focused on (Springham, 1992; Wadeson, 1980). Some group analytic art therapists were so far removed from turn taking that they did not always speak about each or indeed any artworks (McNeilly, 1984).

Claims had been made that turn-taking equalised participation amongst shy and gregarious members because each member gains a turn (Wadeson, 1980). What the literature had not described in turn-taking groups was that the art therapist would often have to reinstate a focus back on the art-maker within their particular turn. Groups did not simply talk about an artwork, from beginning, middle to end and then move onto another artwork. They drifted in their focus on the one artwork. Whilst they might spontaneously return to the discussion of the artwork they would also continue to drift again. That drifting was not of itself problematic as some of what was discussed might well be highly therapeutic. However, drifting could sometimes herald dismissive or chaotic interactions which were problematic. Resetting the group to focus on one artwork was a strategic response by the art therapist to that dismissive condition.

The main tool used by the art therapist to reinstate the group's focus onto the artwork was to explicitly direct attention to their own awareness of and reaction to the artwork. They used mind-directed statements such as "I am really interested in what you said about your artwork (or what you drew) ..." as a means of recruiting other group member's attention to their own. At no point did any art therapist direct attention through an object directed statement, such as simply telling the group to look at the artwork. Attachment appears to be implicated in the individual's capacity to self-regulate both affect and

attention (Lyons-Ruth, Yellin, Melnick & Atwood, 2005; Sroufe, Egeland, Carlson & Collins, 2005) and much of the MBT technique is concerned with generating shared attention as a means of attending to the individual's mental state. This matches the concept of joint attention as a major developmental milestone for the infant to able to perceive the experience of another's mind on a shared target (Bakeman & Adamson, 1984; Hobson, 2004). Facilitating joint attention is at the heart of mentalization-based therapy (Bateman, 2007). This conceptual category matches descriptions of the concept of joint attention in art therapy where the service user is asked to not just focus on the artwork, but also on the art therapist's mind as it attends to the artwork (Isserow, 2007, 2014). However, whilst Isserow had described joint attention as a therapeutic objective, the existing literature offered little in terms of describing how the art therapist acted to make it happen. The descriptions of how the art therapist does this generated by the present study are new findings.

Previous theory has conveyed little about how insistent the art therapist must be in creating a focus when the group is chaotic. The grounded theory shows that the art work is prioritised over the many other eye-catching events in the group which the art therapist treats as distractions from the art viewing task. This is radically different to group analytic art therapy approaches. As Skaife and Huet (1998) describe: “We identify a central problem and that it is that *there is too much material*. In our groups we attempt to work with all of it” (p. 20). In this way their solution was to interpret artworks as encapsulating group process. This approach was within the group analytic tradition which attempted to resolve issues in groups through a focus on meta-level phenomena. The image-for-the-group idea that Skaife and Huet recommended conformed to the analytic group-as-a-whole interpretations. This represents another difference between a mentalization art therapy group and analytic art therapy groups. Karterud & Bateman, (2012) were explicit about

pausing verbal MBT group process when they become too full, unproductive or opportunities for mentalization were being missed. MBT eschews the meta-level focus in favour of narrowing down the shared focus to a particular exchange in the group. This core conceptual category therefore conforms to that MBT principle. Whilst the professional consensus guidelines for art therapy and people with a diagnosis of borderline personality disorder did state that art was a central focus to aid attention control (Springham, Dunne, Noyse & Swearigen, 2012) using the actions involved in developing an art focus to reset the group back to the first principle of turn taking had not been described in the literature.

The cost-benefit calculation has not been given much attention in turn taking groups: In making a choice to focus some phenomena, others must be lost. It is unlikely that the present study can offer much to understand how that type of loss may be mitigated by art therapy turn taking groups. What the study can offer is that the effect of insisting on a focus on one artwork was to increase group cohesion as the next category describes.

"Structured group reflection around an artwork" as a property of "art therapist demonstrates engaged attention." This category showed many features which conformed to the pause and rewind principle outlined as a technique in the MBT manual (Bateman & Fonagy, 2004). Pausing is used as a means to stop and notice what is happening at an affectual level, and then to rewind to link that affect to a recent interpersonal event. It is a central tenet of MBT practice and distinct from analytic group methods which let phenomena play out until the group find its resources to manage a given situation. Pausing halts unproductive phenomena in borderline personality disorder groups, giving service users a breathing space to find their own state of mind, the location of each other's minds and then explicitly attempt to mentalize together. Pausing was identified by focus group observers as a technique used by art therapists on the video

edited sequences in the category entitled "structured reflection around an artwork." This category also had additional features, which may be unique to an art therapy "pause", and so I will now explore these.

When observers described "structured group reflection around an artwork" they noted how chaotic and dismissive interactions would slow down, with a marked stillness descending over the art therapy groups. Similar features of group and individual art therapy session involving the service user(s) silently looking together with the art therapist featured in a number of papers (Greenwood & Layton, 1987; Schaverien, 1992; Learmonth, 1994; Dammarell, 1999). Isserow (2007, 2014) linked these looking together moments in art therapy as points of joint attention enhanced by the art object. Even where group members' attention started to wander in disparate directions, most could be recruited back to a situation where they sat jointly looking at an artwork. This viewing structure was started by the art therapist at the beginning of each video edited sequence. The art therapist did so by asking the art-maker to describe their artwork with the group sitting around it looking intently at it. So when this was reinstated by an insistence on a focus on an artwork, as per the previous conceptual category, it was in effect a return to stage one in the process.

Interest in the artwork seemed more easily rekindled than in other phenomena such as focusing on a comment by a group member. This was enhanced by the art therapist signalling that it interested them. Such phenomenon has been described by Case (1996) who wrote about the aesthetic moment in art therapy, where service users spontaneously became absorbed in stillness when looking at an artwork. She linked this form of reverie as occurring in relation to artwork which linked to an important attachment figure and elements of this idea were found in service user descriptions of art therapy (Springham & Brooker, 2013). It is of note, though beyond the present study to address, that the artworks

made the video edited sequences were had just been made by people who were in an intense therapeutic relationship with each other. Perhaps this made the artworks more interesting and therefore increasing their valence to attract a shared focus.

This mentalizing pause seems to have unique features if it involved an art object. The literature had not identified that when people look at an artwork in an art therapy group, it concretely allocates everyone to a role as either the art-maker or an art-viewer. Reinstating this structure allowed the art therapist more opportunity to instigate shared attention and then offer techniques for reflection. In doing so the task of reflecting on what was said about an artwork was made simpler because it was done in roles which were more easily defined by nature of being concrete. This category might be considered the most basic structure in the art therapy triangular relation in a group setting. As the conversation in the group progressed to talk about other matters, not always linked to the artworks, these roles tended to become less defined or rigid. However, if the group became too chaotic the art therapist could reset the group to the turn taking structure by focusing on the artwork again. Resetting to turn taking reintroduced the advantages of slowing the pace and structuring the reflection around a shared object of attention.

"Emphasis on commonality" is a property of "art therapist demonstrates engaged attention" that contributes to "beneficial art-viewer and art-maker reciprocity." The next stepwise action, "square two", would be taken only if the group became more focused on one artwork. The action here was to add interpersonal complexity back into the shared focus by linking the art-maker's artwork to other artworks. The focus initially remained on how those common elements related to the art-maker's artwork. If this created too much drift away from the art-maker, or the group became dismissive then there could be a return to square one via an "insistence on an artwork focus" by the art therapist.

I found no description of this stepwise action in the art therapy literature. Group analytic literature was very concerned with making links between artworks (Waller, 1993; McNeilly 1987; 2004) but this was approached by meta-interpretations of the group image. That approach was far more abstract than the action of focusing on common elements.

The pace of the stepwise approach appeared to be determined by how much the focus was shared. The concern appeared to be to lose as few participants in sharing attention as possible as the focus widened. In regards to this, observers noted that being allocated to reflecting roles as either the art-maker or an art-viewer made this task simpler and conferred benefits to those in both roles. Those benefits were of a reciprocal character. Connecting the service user with their artwork seemed to help people feel more confident in the group. Observers noted that as well as overcoming mind-blindness by identifying interest from another person in the art-maker's artwork as a product of mind, service users were required to tolerate empathy as a new experience. Conversely helping someone to connect by sharing your views or lived experience as it related to their artwork helped viewers feel they had something to give.

The action of "focus on commonality" has been identified in the professional consensus guidelines in the item entitled: **“**Joint viewing of art objects to highlight different perspectives” (Springham, Dunne, Noyse & Swearigen, 2012, p. 133). Less has been said about its effect. Interestingly it was Ball's (2002) observational research that concluded by noting that increased cooperation between art therapist and child (who was being treated) correlated with an improved focus by the child on the here and now of the session. Moreover, as attention control increased, the child likewise increased the number of self-references and self-depictions in the art therapy sessions. This would appear to

match the observation made by focus groups that increased cooperation in the groups around artworks helped the art-maker to be more present in the group.

Art therapists have developed very little theory about the benefit of being an art-viewer in art therapy groups. However, users of art therapy services have described this benefit. Davis (2014) described the importance of service users naming each other's' images; "Art therapy helped me to slow down what I was going through. The other members of my group were able to identify with my images and listening to them talk about my pictures helped me to recognise my own thoughts and feelings. I then felt I could connect and communicate with people again." (Cover page) Non-art therapists have also suggested witnessing and responding to other artworks as mental images was of key benefit to service users (Karterud & Urnes, 2004).

"Art therapist devolves role" supports "reliable therapeutic interaction" and retains properties of "art therapist demonstrates engaged attention." Once some reciprocal benefit from reflecting from assigned roles had been gained, the group appeared to become more coherent and a much better place to be in. The next stage in the stepwise action is for the allocation of roles to become dispersed. There is an important differentiation to be made here between "art therapist devolves role" and "art therapist appearance of passivity" as it may seem that both imply a *"leave it to the group"* attitude described in table 2. "Art therapist devolves role" is a specific response to a specific condition, namely the achievement of "beneficial art-viewer and art-maker reciprocity". This is a maturing condition in the group. Maturity was equated with service users undertaking the techniques for reflection that had previously been a contribution solely made by the art therapist. Service users moved more freely between using techniques for reflection and contributing something to give as a peer with shared lived experience.

Another differentiation between this action and appearing passive was that the art therapists deliberately ceded their role to the group. In doing so they often backed up that ceding process with explicit validation of how service users had used reflection appropriately. In this sense, the art therapists continued to demonstrate engaged attention, even whilst reducing their activity. This links this action back to core conceptual category one. Such mature interactions seemed to help and that seemed to allow service users to trust themselves and other in the interpersonal setting of the group. This mature condition of the group was an outcome of therapy and can be viewed as the antithesis of dismissive interactions between group members and their artworks. At this stage, if the maturity were to be lasting, it might be argued an analytic approach may be possible. Equally, it might be observed that if this stage of maturity were to be lasting, then this was no longer a group of people who met the criteria for borderline personality disorder. Therefore it is hard to conclude that the analytic approach would be applicable to them.

Stepwise action as art therapy in teleological mode. The above categories conform to the principles of the MBT model but the actions they describe appear to have features unique to art therapy. This involved a stepwise action that has not been identified in art therapy literature. Concrete elements appear to help art therapists achieve shared attention. This includes the artwork as an object and the allocation of roles when that object is the target of shared attention. I am struck that the best descriptions of why this might be effective for borderline personality disorder have come from outside of art therapy. When Karterud and Urnes (2004) reviewed the composition of therapeutic communities for borderline personality disorder in Norway, they found the successful ones had an art therapy component. Their paper included a minor comment that this might be because art therapy operates at the teleological mode of mentalization. To recap, the MBT conception of the teleological mode is that it is a pre-mentalizing level of mental functioning where

intentions can only be inferred if they are concretely demonstrated (e.g. my therapist only likes me if they give me a hug). When the art therapist responded to "dismissive interactions between group members and with artworks" by "demonstrating engaged attention" it was the explicitness of their demonstration of an intention to pay attention to the concrete object of the artwork that was sympathetic to teleological functioning of the service users. The mentalizing task was made simpler and less ambiguous for the service user who, under pressure, was finding mentalizing difficult. At chaotic points, the more demonstrative the therapist was towards the artwork as concrete object, including physically looking at it with explicit references to how their mind was viewing it, the more settled the group became in joining their focus. The settled group then helped group members and the art therapist to reflect. Art therapists who worked with people diagnosed with borderline personality disorder have emphasised teleological qualities of their practice such as suggesting art therapy is a process of "thinking with things" (Silverman, 1991, p. 83) or "structuring thought through art" (Huckvale & Learmonth, 2009, p. 43) but not named it as such. However the interpersonal stance taken to achieve this has been poorly described with the exception of Huckvale and Learmonth (2009) who describe painstaking, detailed focus on thinking about the artwork with the service user.

Having now discussed the conceptual categories that relate to core conceptual category one “art therapist demonstrates engaged attention", I now wish to turn to the next core conceptual category which describes the mutually exclusive action of “art therapist gives the appearance of passivity”.

Core Conceptual Category Two: "Art therapist gives the Appearance of Passivity" Results in "Art Therapist Looses Role."

The effect of the art therapist giving the appearance of passivity had on the group was to increase the dismissive interactions between group members and between them and

their artworks. The art therapist then lost his own role of offering techniques for reflection and everyone became more uncomfortable.

The non-directive approach, involving not intervening, would be advocated by analytic art therapist authors on certain conditions. The literature review revealed that analytic art therapists valued internal over external action. Many wrote about how crucial it was to reflect on counter-transference as a means of processing projections from the service user so that that they do not act them out (Case, 1990; Patterson et al., 2011; Schaverien, 1992). This notion of internal action to reduce external action was given particular emphasis by Greenwood (2000) in relation to borderline personality disorder. The group analytic art therapy model claimed that this process would bring coherence and safety to the service user who would perceive that the art therapist was not overwhelmed by the disturbance they had projected into them (McNeilly, 1984, 2004; Skaife, 1990; Waller, 1993). Moreover, if the art therapist did not interfere the group would eventually find the means to self-regulate. My argument is that this conflates the concept of action with acting out. Acting out was originally a concept linked to repetition compulsion, where what is not remembered (unconscious) is repeated (Freud, 1920). It was later applied to the therapist as their unconscious reaction to counter-transference (Waska, 1999). I agree with Thorne (2013) who described the concept as being overvalued in art therapy, as if the less the therapist acts the more that signifies how more reflective they are. I have often heard art therapists describe how supervisors chastised them for being "too active". Yet, where service users can be mind-blind, it seems logical that they would have difficulty reading whether an inactive therapist is being inattentive and that can be fearful.

An important feature of the interpersonal pressure they generate seems to be that the therapist is not immune. Observers noted that the art therapist needed to intervene with

pausing techniques to regain their own mentalizing, which the MBT manuals consistently refer to (Bateman & Fonagy, 2004, 2006). The sample in this study did not show evidence that observing and doing internal processing of counter-transference correlated with an ability to moderate the unconscious forces as had been claimed (McNeilly, 1987, Waller, 1993; Skaife, 1995). It supported the findings by Hummelen, Wilberg and Karterud, (2007) that people with a diagnosis of borderline personality disorder found analytic groups confusing and distressing. Likewise, one of the main themes found by Springham, Findlay, Woods and Harris, (2012), in examining a service user's perception of art therapy and mentalization, was that the unresponsive art therapist is iatrogenic in treatment for people with a diagnosis of borderline personality disorder.

Summary of Theoretical Implications

The theoretical implications are that the art therapists react to mind-blind interactions in groups for people who have received a diagnosis of borderline personality disorder by using artworks to direct shared mind-based attention to a common focus. Rather than attempt meta-level group-as-a-whole interpretation, they prioritise a simple focus before a more complex interpersonal focus on that artwork. This has not been described in art therapy theory prior to this study. The art therapists demonstrate their own interest insistently which runs counter to the weight of existing art therapy theory which indicates the art therapist is not active in the group in that way. The findings also challenge the position of unique features of art in the triangular relationship. Previous theory had emphasised art as offering unique features, distinguishing the practice and profession from other practices and professions. This grounded theory placed a common mechanisms of change, e.g. human attention above art-based processes, which were construed as a means of directing that human attention.

Having considered the theoretical implications I would now like to outline implications of the grounded theory on practice and training. Following this I then wish to reflect on the implications for future research.

Implications for practice and training. With any smaller scale research project, implications must be cautiously considered. That said, the present study supports claims that it is very important in any therapy that the therapist actively demonstrates their engaged attention to service users who have been diagnosed with borderline personality disorder. The art therapist's interactions with artworks have enhanced therapeutic value if undertaken in the service of demonstrating their engaged attention. It would appear that the directing of attention is most powerful if the curiosity or interest the therapist has is genuine, and not contrived or instrumental as a means of control. Therefore the art therapist must actively reflect and articulate what they either do not understand or are genuinely interested in, within the art therapy group. This action is qualitatively different from a behavioural intervention where the service user is directed to take action according to a protocol or from making an interpretation to deliver insight as a psychodynamic approach. This type of activity is not captured within the directive versus non-directive debates about art therapy practice (McNeilly, 1987; Skaife, 1990). The reflective process the art therapist undertakes is a verbal and active response to problems of attention control in the group. Therapists should avoid long periods of appearing passive, even when they are doing internal, reflective work because the mind-blind features of borderline personality disorder make their passivity very difficult for service users to read, particularly in the early phases of their treatment. In practice it is often difficult for clinicians to self-rate how they come across in demonstrating their attentiveness. Therefore the use of video in training and clinical supervision would be highly valuable.

An implication of avoiding silent or passive practice is that many of the major models of art therapy, such as the group interactive model of art therapy used in MATISSE (Waller, 2004) are not indicated as suitable for groups for people who struggle with mind-blindness, such as those diagnosed with borderline personality disorder.

Implications for Further Research.

The points made above concerning implications for theory and practice in many ways set the scene for thinking about what questions might form the basis of the next phase of research. In addressing this I have divided that research into two categories concerned with theoretical construction and theoretical testing.

Theoretical construction. The present study developed a theoretical description MBT art therapy, but it would possible to strengthen that construction through a number of processes. A future study might usefully compare “on-model” MBT practice with “off-model” practice. Such a study would also add the present research by supporting or refuting the propositions I have made, particularly around the two mutually exclusive categories of active and passive therapist. This could be achieved by replicating the present study's methodological structure but adding in both on and off MBT model video edited sequences as selected by the art therapist. It would be important that the focus groups were not told which video edited sequences were rated as on or off-model by the therapist so that the focus groups could develop their own descriptions based on observation of the art therapist’s actions and their consequences in the art therapy groups. Descriptions of art therapy could then be compared to the on and off verbal MBT practice described in appendix A to see if the actions and consequences supported existing MBT theory.

A next step in strengthening the theory that might be attempted within the basic parameters of the existing study design would be to use the constructionist paradigm to

consider a number of social variations. It would be possible to change the composition of the focus groups for example. Given the idea of mentalization as an everyday, as opposed to professional mental process, it would be interesting for one focus group to be constituted by people who had never encountered the mental health system as providers or users, i.e. the apocryphal person on the street. This study could examine whether those processes of demonstrated attention had the same meaning for persons outside of the whole mental health industry. Another axis that could be altered would be to change the criteria for selecting a video edited sequence. If it were possible to address the ethical issues correctly the group members, rather than art therapist, could select a group experience they felt was therapeutic. Service users I met during the study spontaneously suggested this idea. The value of their selection would be in strengthening the validity of what is construed as good practice used for the video edited sequence selection.

Another approach to theory construction would be to focus on a particular aspect of theory that the present study proposed. For example, the assumption that the art people make in an art therapy group is of particular interest to those involved is one of the central points of valence that the art therapists drew on in their actions. It is important to not take this interest in artworks as a given essence, but to ask how that interest is socially constructed. Future research with this aim could focus on observing a whole art therapy group, including both art making and art viewing/discussion phases. This type of study would closely examine the recursive processes between art-making and art-viewing/discussion, where a personal issue was processed through a repeating sequence as follows: it is represented in an artwork; that artwork directs the discussion phase; that discussion then affects how the next phase of art-making represents the issue and so on (Springham, Findlay, Woods & Harris, 2012). This focus might illuminate how social forces act not only on the development of meaning in artwork when it is presented to the

group but also how subsequent artworks are influenced by that viewing/discussion as a social context. Research into the social construction of art therapy images might reveal important factors to consider about how these processes are negotiated by the parties involved.

A third approach to theory strengthening has been indicated by the way MBT was constructed. This involved cross-referencing practice with psychosocial and biological domains of knowledge. This area would, to my mind, radically open up art therapy theory building and challenge it to move beyond an over-focus on an intra-psychic discourse which I argue it has been entrapped in for three decades. That discourse originated in the psychoanalytic model of a previous time, which contemporary analysts argue is now out of date (Mayes, Fonagy, & Target, 2007). Such an approach might improve an understanding of biological contribution to the social construction of artwork in art therapy. For example, MBT proposed it strengthened therapy by developing practices sympathetic to the biological mechanism involved in attachment and joint attention. This approach had in many respects begun with Evans and Dubowski (2001) in art therapy but has not been pursued since. Since 2001 attachment theory has greatly expanded a neuroscience approach, which has highlighted how much of the brain appears to be an affiliative organ (Allen, 2013). Brain scanning approaches are now being attempted in art therapy (Lobban, 2014). However, I have argued though that whilst agreeing that a neurological perspective on art therapy may offer valuable insights, without a clear hypothesis of the actions involved in art therapy it is difficult to identify which moment to choose to scan in the art therapy process (Springham, Thorne, & Brooker, 2013). In this respect, the type of process research undertaken in the present study, can lay important foundations to more congruently link art therapy practice to neurobiological studies.

In proposing to examine the biological mechanisms involved in art therapy, I argue this need not represent an epistemological contradiction for the social constructionist. In questioning essentialist ideas of biological determinism, social constructionism opens the way for an exploration for an interactive dialectic between the social and the biological. For example, whilst cautioning against the current culture's romance with the brain as a simplistic determinant, Kenneth Gergen (2011) suggested we might consider the brain as both a "lodging" for cultural interaction the individual has encountered and then as one "actant" amongst others within the systems of relationships that individual interacts with. Social constructionism would help to check excessive universalistic claims of determinism that might result.

Theoretical testing. Whilst the grounded theory developed a set of propositions, future research is needed to test those propositions as a theory. I argue the present study lays the foundations for improving the research cycle between theory construction and theory testing in art therapy. For example, a multiple embedded case study approach (Yin, 2009) might be used to examine how theoretical propositions fared in different contexts. Observational research can also offer a great deal to those seeking to construct art therapy manuals for outcome research such as RCTs. Descriptions of practice built from observation support manuals which aim to use observer-raters to measure adherence to model fidelity. A content analysis approach (Krippendorff, 2004; Neuendorff, 2002), using multiple raters could appraise new video edited sequences to understand the prevalence of the propositions and their outcomes. This would also ascertain whether the descriptions were of use in rating therapeutic practice. This would rectify significant threats to validity identified in the MATISSE RCT study by Holttum and Huet (2014).

Perhaps the most significant implication for research is that observation of art therapy groups with adults is possible and so could offer a great deal to art therapy theory because it is a ubiquitous area of practice.

Epistemological reflection. Finally, I would also like to make a comment about my personal journey through the research study. I understood that epistemology was necessary to force important questions about what is assumed within the study area. I had not anticipated how I would myself become more widely sensitised to the social construction of mental illness in my daily working life in the NHS. This is not a comfortable experience. In many ways the present study confronted me with the ordinariness of the processes of attention used within the profession of art therapy. Yet professions habitually have to make defences for their effectiveness and against quackery based on claims of special actions. The habitual nature of that defensive process can itself be very blinding to inappropriate reification of professional claims. I feel that pressure myself and a result of undertaking the present study has been my assumptions about the specialness of what I, and my colleagues in that system are paid to do have undergone continuous challenge. I have reflected that I personally feel very proud of the egalitarian roots of art therapy, but feel concerned that in attempting to prove its worth as a psychological therapy some of that ethos may have become lost. Many art therapy models influenced by group analysis claim to be emancipatory in their aim, but their method firmly placed the art therapist as an expert in the service user's unconscious, who by default is cast as passive and unwell. This seems at odds with my experience of art therapist colleagues who in my view try hard to work side-by-side with those who use their services. I recognise this perception is a hunch, but I would be very interested in using it as a starting point to undertaking a discourse analysis of art therapy literature, including my own, to understand more how art therapy theory positions therapist and service user. Similarly I would be interested in

understanding the discourse used within art therapy practice by audio recording sessions and likewise subjecting them to discourse analysis.

Strengths

The strengths of the present study were that it researched art therapy in a naturalistic setting. It involved a clinically significant population. It used video-recorded observational methodology which has generally been neglected in art therapy and specifically had not been applied to adult populations or art therapy groups, even though this is a common form of treatment. The study was an in-depth exploration of a homogenous sample in terms of practice which shared a therapeutic approach, a specific action within art therapy and a shared type of treatment context. It involved 16 viewers from multiple-perspectives, including service users. This had not been attempted before in art therapy. Observation generated data analysed by grounded theory produced descriptions of practice which have been lacking in at therapy literature. Because the practice description derived from observation and its taxonomy describes what can be seen in art therapy it is therefore more likely to have utility for manualisation for research which might seek to use observation to establish practice fidelity.

Limitations

Limitations of the present study were that the video edited sequence samples were small. It is uncertain at this point how representative those samples were of MBT art therapy practice with people diagnosed with borderline personality disorder. The research did not address all aspects of art therapy group practice, such as making art. It therefore offered limited understanding about the recursive relationship between art-making and art-viewing/discussion. More needs to be understood about this relationship as a means of understanding each action within it. The study did not compare MBT art therapy to group analytic art therapy examples. It did not explicitly compare “on-model” MBT practice

with “off-model” practice. The art therapist rated the therapeutic practice as therapeutic and no other method of establishing whether practice was therapeutic was attempted. Another limitation was that I had a dual role as a treating art therapist and a grounded theory analyst. Whilst the researcher practitioner role has been common in art therapy (Gilroy & Lee, 1995), it is possible that the separation of research analyst and treating art therapist roles, or indeed the inclusion of the other treating art therapists (or other observers) in the analysis may have produced different results. Belief in an intervention can influence positive results in research (Bateman & Fonagy, 2008). Whilst the study produced a grounded theory, that theory has yet to be tested and may need further development.

Summary

I believe it is important that the methodology used in the present study represented a significant innovation in art therapy research. This is to my knowledge the first time that art therapy groups were observed and that observation occurred across multiple clinical sites. It was also the first occasion that art therapy service users rated videoed art therapy as partners in the research process. This involved overcoming significant ethical issues and cultural barriers within the profession of art therapy. I believe the service user view added uniquely to the construction of the grounded theory. By publishing this methodology I hope to contribute to a cultural shift which presumes their involvement in research, rather than excludes their view as lacking insight or having nothing to offer. I suggest the originally of the findings of the study indicate not only that such methodology is now possible, but essential in theory building within art therapy.

The study asked how art therapists interact with service users and their visual artworks (the triangular relationship) during the discussion section of mentalization-based art therapy groups aimed at treating people with personality disorder. The grounded theory

adds new dimensions to how the triangular relationship has been previously construed. Psychoanalytically informed art therapy theory had previously posited that the triangular relationship was a structure with inherent properties for illuminating unconscious processes. By contrast my thesis constructs the triangular relationship as a focus the art therapist imposes as a strategic response to chaos in the group. The triangular relationship is theorised as a description of the art therapist's pragmatic action. They are of course helped in this by the valance between people's interest in art that they had just made and the simplicity of a material object for creating a target for shared attention, but I do not see these as inherent qualities because they occur in a situation constructed by the art therapist. In line with the social constructionist epistemology I argue these differences is move theory from the essentialist to the purposive.

As a final reflection on the grounded theory that resulted from this research, what struck me was that so much of what was revealed involved human attention. Art therapists seemed to working hard to simplify, demonstrate, alert and direct human attention as a primary therapeutic tool. Given that so much of the evidence points to the severe problems that borderline personality disorder seeks to describe are highly influenced by neglect and invalidation of the individual's experience (Levy, 2009; Zanarini, 2001) e.g. deprivation of human attention, this finding has both a theoretical elegance in Kazdin's (2004) terms and concerning sense of humanitarian tragedy.

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Appendix A

Research Diary Extracts

Introduction to Research Diary Extracts

I was very much guided in writing a selecting these extracts by many of the social scientists who encourage reflexivity. Many of these ideas are familiar to me from therapy and from my art background, but I was unfamiliar with how they related to research. I was particularly helped by an early paper helpfully entitled "From anxiety to method in social sciences", Devereux (1967) said

> “The researcher should not ignore the interaction between object and the observer, hoping that in time this interaction would fade away if (s)he for a sufficiently long time continued to act as if such an interaction did not take place ... researchers should stop exclusively underlining treatment and manipulation of the object. Instead they should simultaneously and sometimes exclusively reflect and understand their role as observers” (p. 19).

I read Freshwater (2005) criticism of reflective logs where they fail to differentiate between confessional tales and textural radicalism. Confessional tales were referred to as “mini-melodramas of hardships endured and usually overcome in the research process” in order to give an impression that an objective reality was finally arrived at. Textural radicalism makes clear the role of the voice of the researcher amongst other voices in shaping analytic decisions. In the extracts presented here, I have attempted to remove my own mini-melodramas in favour of including those points where my voice needed amplification in the analytic process. But I found this was not as easily differentiated as my first reading of Freshwater led me to think. What helped me to move on from this was the chapter by Susan Leigh Star entitled "Living Grounded Theory:

Cognitive and Emotional forms of Pragmatism" in the Sage Handbook of Grounded Theory (edited by Bryant and Charmaz 2007):

> "In conclusion I would like to return to how grounded theory permeates my way of seeing the world in connection with pragmatism embedded in my everyday action, almost a spiritual tool to decanter my own assumptions and constantly try to take the role of the other. That is to embrace a continuous, embedded, imbricated, multiple, constantly compared way of making sense of myself" (p. 90).

I realised that the grounded theory analysis could not be divorced from one's life or melodramas because they shape how we make decisions. Grounded theory seems to build on the way that humans make sense of their world through interaction and abstraction. For this reason, the extracts here include a great deal of my lived experience around the PHD because these experiences were a part of decision making and helped me to sensitise myself to the data. Perhaps someone else with different experience would have made different choices, but all that would also be clearer if the research was contextualised within their lived experience too and declared as such. I would like to start the research diary with the following table A1 which aims to give a brief overview of the timescales for the main milestones in the PhD and to outline the associated activity which contributed to the study.

Table A1:

PhD milestones and associated activity

Year	PhD Milestones	Associated Activity
2009	Amended original proposal to concentrate on identifying unique features of art therapy	BAAT special interest group for personality disorder started Art Therapy Practice Research (ATPRN) symposiums (ongoing)
2010	Developed methodological approach to main study. Undertook feasibility study.	Formed ResearchNet: service users, carers and professionals in research. Convene first Attachment & The Arts (A&TA) conference series. Keynote: Peter Fonagy. Advanced MBT training. Assist qualitative study to MATISSE Greece: MBT teaching
2011	Run and evaluate focus groups for feasibility study. Recruit research sites	MBT: train the trainer A&TA keynote: Jeremy Holmes. 2 x ResearchNet papers Norway: MBT teaching.
2012	January: Obtain ethics approval for main study.	Undertake experience based co-design project (use of video in patient experience) A&TA Keynote: Paul Gilbert Edit special Issue of *International Journal of Art Therapy* on personality disorder
2013	March: Obtained video edited segments Recruit and run main study focus groups	A&TA Keynote: Iain McGilchrist Singapore: MBT teaching Publish Audio Image Recording feasibility study results.
2014	Complete grounded theory analysis	AATA keynote: Antonio Damasio Publish on ATPRN Evaluate peer support initiative Oxleas.

As a brief comment on this, I realise I did a great deal of publishing in 2012 because I was waiting, very anxiously for one site to produce videos. I may have been jumping the gun, but my literature review had made me very aware of the gaps in the literature. So I filled them a few of them with papers that I felt I was sitting on. I realise how helpful it was to have been chair of the professional body. I was able to co-develop the attachment ad the arts conference series through BAAT by asking the authors that I kept encountering in the literature. This was highly beneficial in opening me up to new ideas. I also found that they were very well attended which represents another social process in theory building.

Having outlined the context of the PhD, I have extracted the following segments from my diary reflections because they were pivotal in the study. These accounts represent conversations in supervision, exchanges with peers and with other professionals. I lay this out in this diary form because, in common with all science, the major theories in art therapy were not derived from a positivistic scientific approach immune from social phenomena but instead have their root in the interaction of real people (myself included) within a socially constructed system (the profession). In this respect I have attempted to locate how my social positioning within art therapy contributes a particular perspective.

Bracketing Experience Prior to the PhD

At an early point in reviewing the art therapy literature I realised I was constantly feeling annoyed with what I was reading. That irritation kept feeding into my writing, resulting in black and white summaries of papers as good or bad, rather than mining their particular contribution in a nuanced way. It helped to spend some time diagramming my road to the choice to do a PhD (Figure A1).

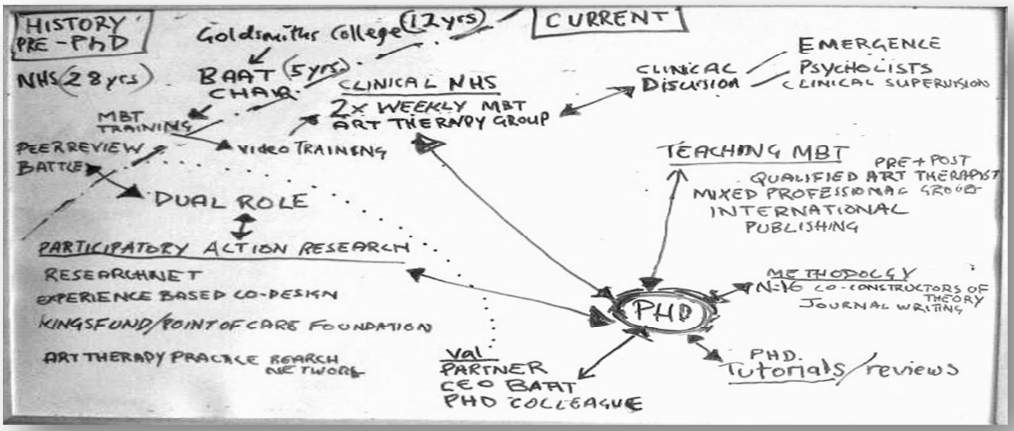


Figure A1: Social positioning of myself researcher in field of study

This image was useful for me because It showed just how immersed I was in the art therapy profession. I could also see a very strong link developing between practising as an art therapist and the need to have others become part of theorising that practice. It

located my irritation that was affecting my writing. I wrote in my diary: "When I cite art therapy authors I am often writing about people that I know and variously like and dislike." It's hard to do justice to how helpful this insight was. Just being able to write this helped to reduce the power of that irritation. I still felt irritated by found I was much better able to be fair and balanced. I'm sure some of that irritation remains in the literature review, but I believe it is more balanced and warranted - people in positions of power made some big claims and it caused problems. I think this is detectable in the literature rather than in just what I know of their impact from being in art therapy.

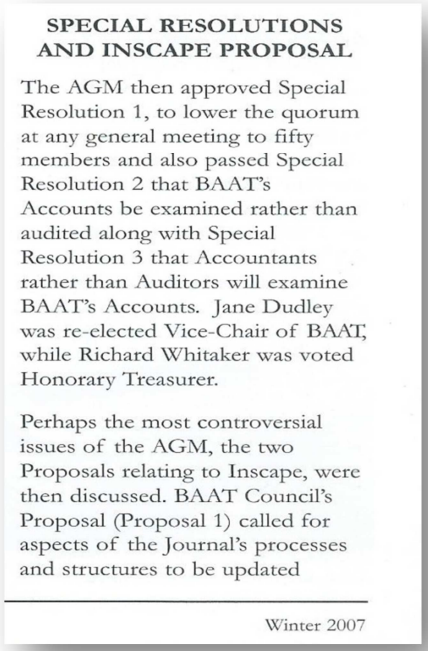
I wish now to take a small corner of this diagram (middle left of Figure A1) entitled peer review battle, as this represented a particularly difficult aspect of that journey.

Widening Theory Makers and Social Constructionism

The impetus for stating the PhD had its origins in my lived experience. Since 1993 I have always combined clinical practice with either teaching or some form of research. However, I left the position of course leader in art therapy at Goldsmiths University in 2005 because I found the extreme version of group analytic art therapy adopted there stifled any other type of thinking or method of enquiry. I was very angry at the way that approach gave such dominance this group of people with the profession: any disagreement was interpreted within the model and therefore the model itself could never not apply thereby reinforcing the position of power for those people. How infuriating and how far away from the needs one meets in clinical practice. I moved from education to became chair of a body of peers and found the debates stronger. The art therapy professional journal, Inscape, was edited by those in education and membership told me that many of their submissions to the journal had been rejected because it was not in the group analytic model. My aim as chair was to develop a means whereby the journal

became properly blind double peer review and that the role of peer should opened up to include art therapist members of BAAT, i.e. the readership. My involvement in challenging of that process of theorising art therapy created a very hostile campaign and culminating in shouted accusations against me personally that I enviously attacking the elders of the profession and so was ruining something very precious.

I include here an excerpt from the 2007 British Association of Art Therapists Newsbriefing report on that AGM (Figure A2 - A3). It deeply affected me.



SPECIAL RESOLUTIONS AND INSCAPE PROPOSAL

The AGM then approved Special Resolution 1, to lower the quorum at any general meeting to fifty members and also passed Special Resolution 2 that BAAT's Accounts be examined rather than audited along with Special Resolution 3 that Accountants rather than Auditors will examine BAAT's Accounts. Jane Dudley was re-elected Vice-Chair of BAAT, while Richard Whitaker was voted Honorary Treasurer.

Perhaps the most controversial issues of the AGM, the two Proposals relating to Inscape, were then discussed. BAAT Council's Proposal (Proposal 1) called for aspects of the Journal's processes and structures to be updated

Winter 2007

Figure A2. Excerpt from 2007 report on the AGM

BAAT AGM 2007

through a new operational policy. This was intended to balance editorial freedom with democratic accountability to the membership via BAAT Council, and with an emphasis on an improved peer review structure in line with other therapy journals.

This Proposal called for a vote of support from the membership to produce a final draft of the operational policy (to be brought to next year's AGM for final approval).

Proposal 2, put forward by Caroline Case and Joy Schaverien, asked for the AGM to approve, firstly, a vote of confidence in the editor, Tessa Dalley; secondly, that the Editor and editorial board of *Inscape* have editorial freedom and the final say on the election of members to the editorial board, and, thirdly, that the current *Inscape* editorial board be elected at the 2007 AGM for a minimum of three years, and decide on their own internal processes and successors with no external consultation.

Neil Springham explained that after consultation with BAAT's lawyers it became clear that Proposal 2 was inadmissible. The proposal breached Article 30 of BAAT's *Memorandum and Articles of Association* which states that all the affairs of the Association must come under the control of the elected Council of management who are responsible for the legal functioning of the Association.

This proved controversial and sparked allegations of censorship from supporters of Proposal 2. Although there was no option for BAAT to act outside Companies Law, time was allocated in the AGM for Neil Springham to clarify the procedural aspects of this action. The debate raised by both proposals then concentrated on Proposal 1 for which members could vote 'for' or 'against'. Tim Wright said *Inscape* needed to develop and clarify its editorial processes in order to ensure the profession had a journal that could meet the stringent standard for inclusion in international research databases. This would provide evidence of the effectiveness of Art Therapy and thereby help make the case for expanding and developing services. He added that the changes in Proposal 1 had the support of *Taylor and Francis, Inscape's* publishers.

Requests were made by Marian Liebmann and Robin Tipple for the withdrawal of Proposal 1.

The final vote for Proposal 1 was 78 For, 17 Against, and 26 abstentions. BAAT Council's Proposal was therefore carried forward.

Report by Louise Smart
Photographs by Sally Nicholson

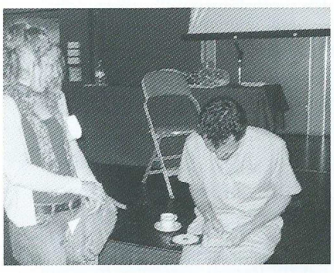
Please note this report does not replace the official Minutes of the AGM which will be published nearer the time of the next AGM scheduled for Saturday, 14 June, 2008) with fuller details of questions, answers and comments.

The full texts of the reports from the Chair, Vice Chair and Chief Executive are available on the BAAT website www.baat.org

Monica Gobourne

Debbie McCoy (left) with Andrea Gregg

Diana Velada (left) and Deborah Bryden (BAAT Hon. Secretary)



Autograph signing!

Figure A3. 2007AGM report continued.

I have kept the photographs of the AGM attendees on the day as to my viewing it demonstrates that professional theory is built by people coming together in a social context. Note the autograph signing, which positions art therapists personally in senior and junior roles. I would add that it is a social context from which I am not immune.

I was trying to think about my epistemological position. I felt I was critical realist, but these experiences were very powerful in shaping my location in social constructionism. If ever proof were needed that professional theory was the construct of some people and the exclusion of others this battle convinced me.

Decisions about How to Represent Art Therapy

This is a sheet from my diary (Figure A4). I am attempting an option appraisal about what to present in art therapy:

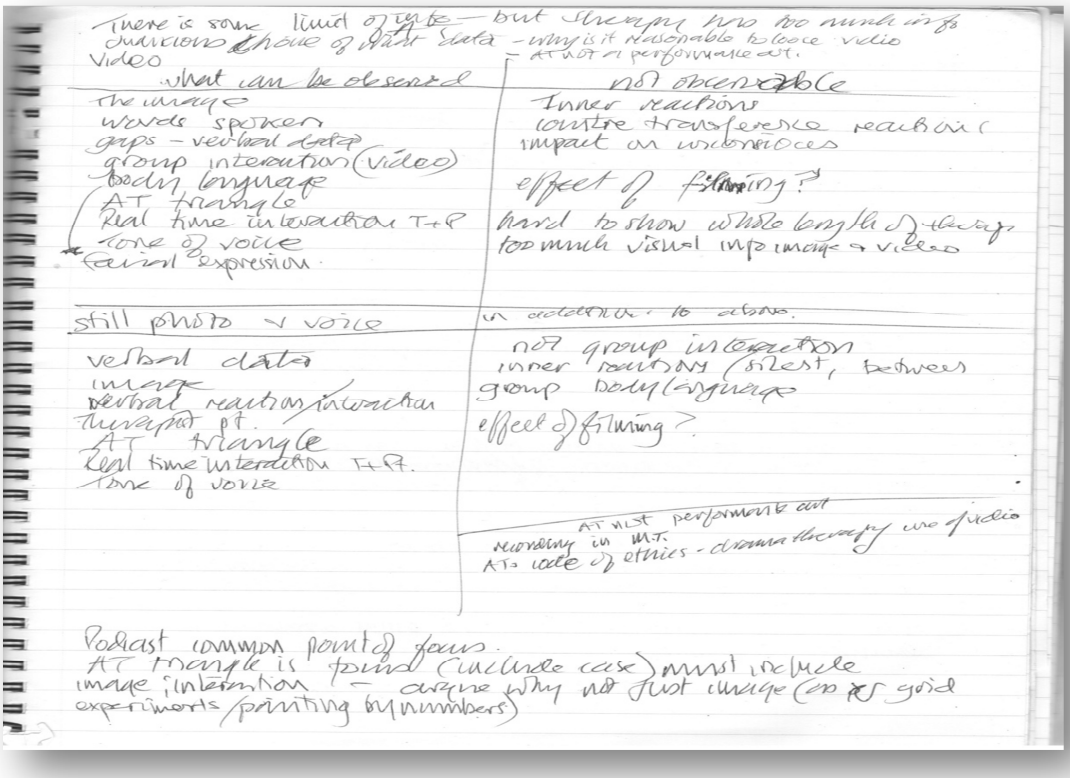


Figure A4: Mapping of the options for presenting video to focus group attendees, pros and cons.

At this point I was listing the various combinations of video films of action in the room, photographs of artworks, and audio image recordings. The range of options is almost overwhelming. What struck me from the literature review I undertook prior to the study was how few attempts to open up clinical practice in art therapy compared to other forms of psychological therapy there had been. In trying to understand what goes on behind the art therapy studio door I needed to develop procedures because so few had been attempted before. It seemed ironic to me that a visually based therapy has been so little subject to observation. My sense now is that the difficultly is not that art therapy is not visible, but that that the various possibilities of combing viewing artworks and human interaction are potentially overwhelming. I found observation began with loss: I had to start with pragmatic compromises and that incurred limitations for the claims that any such study might make. There was always some other way I could have approached the study. I still acknowledge that there is much to discover about how to represent art therapy. My solution was pragmatic in the end. It took more time than colleagues could give to use an audio image recording and a video of the group. Service users did not particularly value the second listen in the ResearchNet focus group, but it's possible this may be useful for future research. Perhaps that research would need to be where people can be funded to give their time. I am very happy with the results of process I used but need to acknowledge that alternatives always exist. I find these alternatives fascinating.

Building Trust as the Basis for Research.

When the present study started there were powerfully prevailing attitudes that observational methodologies were inappropriate to art therapy (Dolphin, Byers, Goldsmith & Jones, 2014; Schaverian, 1995) and concerns that breaking confidentiality (in producing a video) damaged service user trust Dudley (2004). Very little observational research had

been attempted in art therapy at that point. I was by no means sure that enough, or any, art therapist would be willing to volunteer their practice.

I found I needed to be very proactive about tackling those assumptions at a professional level in order to make the research possible. I undertook a series of continuing professional development seminars through the BAAT about confidentiality in legal, ethical and dynamic terms. I showed video of my own clinical practice with staff colleagues from the feasibility study to BAAT's special interest group for personality disorder. I found this very difficult to do and feel that difficulty may reveal an important force in the practice research divide. I found myself anxious in that compared to the art therapy literature, art therapy practice looked a mess (even when it was with a staff group). I had to trust that my clinical work would not be dismissed and that was hard. This was an important procedure to consider because the literature review revealed that whilst confidentiality was the main objection to allowing a video camera into therapy, clinicians could be liable to attribute their own anxiety about having their clinical work viewed by professional peers expressed to a concern for the service user confidentiality (Gillet al., 1969; Shepherd, Salkoviskis & Morris, 2009). In other words, while confidentiality is essential, I found that establishing trust was the make or break the process of this research.

I imagine I would have really struggled to enter the profession as a non-art therapist and say "show me what you do." My position within the profession coupled with the fact that I was subjecting myself to the same scrutiny as I was asking others for, was essential for recruitment at this stage in art therapy culture. I led my request with an admission that practice looks messy. To support this idea I wish to explore a site where I nearly lost a research participant. I start by including a witty email from the art therapist colleague who agreed to submit video because it shows the level of trust needed to share the mess of real world art therapy practice (Figure A5).

To:'Neil Springham' <Neil.Springham@oxleas.nhs.uk>
Date: 18/07/2011 17:25
Subject: RE: PD & PhD

Hi Neil

Certainly I would be interested, if not somewhat dreading opening up what happens in my group- and how I handle or not handle the stuff that goes on! I remember a situation where two clients nearly ended up in a fight!!! but then again how are we to know what really helps and what doesn't ??? (fighting doesn't - I worked this one out)

What will need to happen is for you to submit a research proposal to the R&D here in [redacted], helps if it has already past a R&D grilling in your trust?

The group I'm doing fits your criteria.

I'm doing another group based on MBT lite- structured exercises, involving discussions/pairing up, templates, me helping out with the art, me doing art, clients taking on the role of the therapist etc. So a pragmatic approach??, - its an art group, underpinned by an MBT educative approach!!! At times I'm sure I'm not a mentalising therapist !! (All the clients in the current group pass the threshold for 4 or more axis 2 diagnosis - so they fit!)

What next?

BW

[redacted]

Figure A5. Email from treating art therapist

Having gained two art therapists trust I then attempted to engage their team. My clinical team supported me readily. Another team was likewise enthusiastic and wanted to learn about observation so that they could also routinely apply it to clinical for supervision. However, in one site the clinical team changed its establishment during the process of collecting video data. The team remained an MBT service by name but new therapists joined who had a psychodynamic approach. The new team objected to the research on the grounds that they should not ask service users to consent because it would adversely affect them. The situation only changed when those therapists undertook MBT training. This resulted in a delay of nearly 12 months in gaining a video edited sequence from this site because the team raised concerns about the impact of observational research on service users. Interestingly in all sites every service user except one readily consented.

The importance of building trust is that if this not been successful, it would have affected the entire project. Yet it was a matter of procedure because I was unable to meet

the team and did not gain the therapists trust. I would not underestimate building trust as major factor at all levels in future observational research.

Zoning out in a Service User Focus Groups

Extract from Emergence focus group:

Participant B: "I find it really difficult to talk about this one because it has triggered too many things ... so I feel quite “zoned out” after watching that ..."

Focus group moderator: "It touched too much personal stuff?"

Participant B: "Yeah, it was too ... yeah, yeah. I just feel like “zoned out” after that. I didn’t like the fact that he was sat separate ... it should have been full circle I don’t like it when the therapist and that’s the other thing I don’t like the way that he was separate to the rest of them ... erm, I’m sure I am going to be able to talk about this to be honest ..."

Focus group moderator: "Because of what it brings up for you?"

Participant B: "Yeah"

Participant C: "I think it’s a really big thing about feeling very isolated and very alone and erm so completely I understand what you are saying."

Focus group moderator: "And you have both been saying this would touch off a lot for everybody ..."

Participant B: "yeah"

Focus group moderator: "Any thoughts from others?"

Participant D: "I share a sense of erm ... the pain and discomfort of watching it really and... and ... what is so apparent in the group, and like everybody being able to relate to that. And it very much relates to my own experience, it’s something very resonant about the issue that is discussed ... umm ... also I think people’s body language as you have said (participant B), you get a sense of how hard it was

for people to stay in the room, to talk, or not to talk and just “be”... but to be among other people erm and the kind of efforts that the group were doing were making to be there for one another and that is, you know very powerful ...

Focus group moderator: "I think it sounds like all of you can really empathise with that and perhaps in a way that could be resonance and depth, so I think that’s interesting ..."

Participant A "It might interfere with perception and analysing that video we are really struggling with our own dialogue at that point ... because it’s just triggering ... I had my mind really start wandering to thoughts about my own situation and I had to really bring it back and realised I’d missed something ... so there might be less of a quality feedback ... but ..."

I contacted the focus group conductor. He told me that this had only been a moment and that the service user researcher had been able to feel OK after this. I spoke with the research director and she said this was no uncommon. We had a very helpful conversation about how often this occurs for people who have lived experience of mental health. She said that people in Emergence could feel rather patronised if this were used as reason to keep them out of research. It happens so much and so much can trigger them that professionals merely demonstrate how little they understand about how hard it is to live with these experiences daily. The research was very meaningful to them. I spoke about the issue with ResearchNet and they said exactly the same thing. I had a strong sense of the resilience of service users from this perspective and had an uncomfortable sense of how narrow a therapist's view is of service user capacity.

Appearing Passive and Appearing Responsive - Art Therapists seem Interested.

Prior to the focus groups, I had finished a week long teaching session on art therapy and mentalization at LaSalle University, Singapore. This involved looking at the

generally MBT model and the art based adaptations. Students made artworks, performed role play, watched attachment theory videos and listened to MBT service users describe their artwork using Audio-Image Recordings. At the end of the training the students spontaneously wanted to take photographs to remember the course. What they spontaneously chose to do in those photographs was to re-enact the still face experiment (Tronicket al., 1975). These are presented here (Figures A6 - A7).

Figure A6. Students and tutors' initial sitting for a group photograph.

Figure A7. The same students and tutors sitting (mostly) adopting still faces

I asked about this and the students said that in it had had a profound effect on them to see the still face experiment, to role play being distressed service users and to be met with passive therapist stance. In other words they had prioritised the signalling of

emotional tone over art activities in a similar way to the grounded theory results. I am fully aware that this did not constitute an experiment, but present it for consideration in two ways. Firstly, that from the entire list of activities they experienced in the training, they could have chosen many ways to remember the session such as holding up their artworks etc. Yet they chose the emotional signalling of the person of the art therapist to remember the course by. What might this add to the grounded theory? The American social scientist Randall Collins viewed theory as essential for individuals and groups to understand their world. When describing theory at its most profoundly basic level he said: "Theory is what you remember." (Collins, 2004, p. 3). Social signalling is what they remembered most. The second is that I ask the reader to share in a thought experiment. In comparing particular individuals between photos, how would it feel to be distressed and to meet each version of them?

The Dynamic of the Obvious

In this extract, I found there was a very strange experience in the coding process of the grounded theory. I have written in the discussion about the surprise that demonstrating attention became central. I doubted it for some time, until I was able to trust the data to lead me to that conclusion. My worry was that it was too simple, too generic and too obvious.

To understand that experience, and how I overcame it, I include a piece that I published in the Guardian online (Figure A8). This also shows the increasing awareness I was gaining that sensitivity needs to be paid to triggering service users in research. This led to an exchange which greatly affected my thinking in the PhD.

Toolkit uses patient experiences to improve mental health services

Neil Springham and Ami Woods

Guardian Professional, Tuesday 7 January 2014 09.00 GMT

Staff at Oxleas NHS foundation trust found that communication had a powerful effect on patient experience of admissions.

Mental health acute wards are frightening for patients and stressful for staff.

Patients feel at their worst and are often terrified about what is happening. Staff must process a high volume of admissions, many of which come with additional complications relating to factors such as housing or benefits.

For these reasons, the patient experience team at Oxleas NHS foundation trust decided to take a new approach to these pressures. The experience-based co-design (EBCD) toolkit is a distinctive approach, which captures the experiences of patients, carers and staff through discussion, observation and filmed interviews; then brings them together to explore findings and to work in small groups to feed this into service improvement.

The EBCD toolkit has been used effectively in physical health, but we found no evidence of its use in mental health when we began – and we have since linked up with others using it in mental health whose experiences mirror our own.

The approach is distinctive because it enables patients and service users to tell their own stories deliberatively. We used EBCD for two years on Betts ward, an acute mental health ward in Bromley, and have found it very powerful. However, because of its high impact, we needed to adapt the toolkit and tailor it to mental health.

For example, we found that after talking without preparation participants were initially unable to sleep because they had recalled and relived the worst moments of their lives. It became clear that the experience of acute mental illness itself, along with the fear, stigma and shame still attached to sufferers, meant we were asking a lot of participants. So we built in additional support for service users, to slow down recall and allow users to control the process. We did this through our ResearchNet group, where service users, carers and providers work collaboratively to improve services.

The result of our EBCD work was striking. In terms of assessing patient experience, there is nothing that can match people describing what they went through directly to camera. Their descriptions of what worked and why gave us information impossible to get any other way.

It became clear that it is not procedural approaches (such as diagnosis or care plan), which set the tone of an admission, but human contact with staff. Even the briefest of human communication had a disproportionately powerful and positive effect if it was based on an empathetic approach. We found this even when patients felt they were suffering delusions or were closed down and uncommunicative.

At the viewing, staff had tears in their eyes, saying the videos put them in touch with what they came into nursing for. Rather than being a criticism of nursing, the videos were a boost for staff, letting them know that they as people were the most important factor for service users in an acute state of distress.

Yet the effect of the films was not limited to ward staff. Senior managers also received reliable data about what patients experience and value. They were then able to use those descriptions to redesign processes around the ward and to bring that human contact to the foreground, on an equal footing with better-established clinical and administrative priorities. The ward was able to build its procedures around the emotional touch points identified by EBCD and has managed to reduce its complaints by 80% over a 14-month period.

Perhaps most surprising was the effect on our ResearchNet group. It was not our intention to be therapeutic. Yet, while the process could be stressful at times, EBCD helped users structure their lived experience and seemed to reverse the effect of stigma attached to it.

It was hard, but people feel very proud of the personal experience represented on film because of the positive effects they have had.

Neil Springham is head of arts therapies and ResearchNet co-ordinator at Oxleas NHS foundation trust. Ami Woods is art therapist and ResearchNet member at Oxleas NHS foundation trust. The experience-based co-design toolkit was originally launched by the King's Fund in 2011. A revised version, incorporating user feedback and the addition of four case studies, was launched in November 2013.

Figure A8. Guardian online article

I was pleased to be published but was very irritated by some of the comments on-line (and will probably not read them in future!) Someone said "are these the geniuses that found the sun come up in the morning" others described what we did as blindingly obvious. From this article, Nick Clegg visited the Trust because the government was launching its 25 point action plan. I was asked to describe our work with Experience Based Co-design, as an innovative approach to mental health. This is from the BBC website (Figure A9):

BBC: The Deputy Prime Minister, Nick Clegg, visited Green Parks House in Bromley on Thursday last week as he prepared to launch a new mental health action plan.

Mr Clegg was joined by Mental Health Campaigner Alastair Campbell. They spent time talking to staff and people who have used our services and visited Betts Ward where they were given a warm welcome.

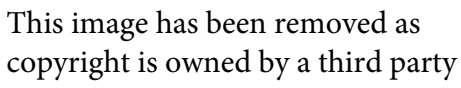


Figure A9. Nick Clegg visiting Oxleas

This picture has some unintended comedy to it. We showed our videos to Nick Clegg and explained the powerful outcome on the ward. He said how moving they were but turned to the ward nurse and said "I don't know how to say this without being rude, but many on the things service users said were pretty basic, like saying hello. Are we saying that doesn't happen on mental health wards?" We now call this the Nick Clegg question, and it's a good one. I suddenly went from feeling we were presenting a "cutting edge" approach to acute mental health to somehow suggesting saying hello was something we had not thought about. Yet, saying hello is cutting edge on an acute ward, it isn't too obvious. The obvious things get destroyed by human distress - they are not obvious. It helped develop core conceptual categories, particularly about demonstrating attention. I also realised how crucial it was to represent the problematic group for people with a diagnosis of borderline personality disorder as the context for actions which might seem basic, but just are not when you are in that situation. This is why I chose to present the context of a dismissive art therapy group before presenting the art therapy approach. One Nick Clegg question is enough.

Appendix B

Mentalization Checklist 46 Point Scale (Bateman & Fonagy, 2004, p. 315-316)

- Taking a genuine stance of not knowing but attempting to find out
- Therapist asks appropriate questions to promote exploration
- Adequate consideration of patient's understanding of motives of others
- Use of transference tracers at beginning of therapy
- Using transference interpretation to highlight alternative perspectives
- Appropriate confrontation and challenge unwarranted belief about self and other
- Avoid presenting the patient with complex mental states
- Avoidance of simplified historical accounts
- Avoiding confrontation with patient when in psychic equivalence mode
- Identifying and addressing pretend mode of mentalization in the patient
- Addresses the reversibility of mental states and challenges psychic equivalence

Working with current mental states

- Attending to current emotions
- Focus on appropriate expressions of emotions
- Linking with immediate or recent interpersonal contexts
- Relates understanding in current interpersonal context to appropriate past experiences

Bridging the Gaps

- Reflects the patient's internal state in a modified form
- Recognizes the patients experience of psychic equivalence
- Focuses attention of patient on therapist experience without being persistently self-referent
- Negotiates ruptures in alliance by clarifying patient and therapist roles
- Develops a transitional "as if" playful way of linking internal and external reality in

sessions

- Judiciously uses humour

Affect Storms

- Maintains a dialogue throughout the emotional outburst
- Initially attempts to clarify the feeling and any underlying emotion without interpretation
- Addresses possible underlying causes within patients current life
- Identifies triggers for the storm in patients construal of their interpersonal experience prior to it
- Links affect storm to therapy only after storm has receded

Use of Transference

- Shows clear build up over time to transference interpretation
- Only uses transference interpretation when therapeutic alliance is established
- Transference not used as simple repetition of the past
- Transference is used to demonstrate alternative perspectives between self and other
- Avoids interpreting the therapeutic relationship as part of another relationship that the patient currently has or has had in the past
- Transference interpretations brief and to the point
- Refrains from the use of metaphor
- Does not focus on conflict

Appendix C

Written Information for Participant in Feasibility Experiential Art Therapy Group

Dear Participant,

As part of my PhD I want to explore whether art therapy groups can be video recorded. I would like to invite you to take part in an experiential group for this purpose. This will involve you taking part in a training group which we will record on audio-video and take photos of your art work. This is not personal therapy so you will not be expected to talk about personal issues. Our focus will be on the here and now of the workshop. This will include looking at one's reaction within the group and other people's imagery. The main focus will be on the role of the therapist in mentalization, but your work will be shown. After this I will show the group an edit of the work we have done together as a way of understanding mentalization. We will relate this to theory and the self rating scales used in mentalization. In addition to this I would like to show the video and artwork to others to help with teaching and research about the subject. This involves the work going into the public domain so I would like to explain the level of consent you would be asked to agree to. I will record the whole session and will store this confidentially. I will give you a copy of this recording for you to agree consent. You are perfectly within you rights to withhold consent to any part or whole of the material you have taken part in. This will not be a problem. The video will be viewed by two focus groups, firstly ResearchNet and secondly other art therapists within the Oxleas NHSTrust.

Thank you for considering taking part in this session which I hope you will find useful.

Neil Springham, Consultant art therapist

Appendix D

Letter to Feasibility Focus Group Participants

The focus group is the pilot study part of the research for my PhD. I am trying to look at how other people see art therapy, what sort of constructs they put on it and how they would describe it. I have selected a recorded segment of an art therapy group which I feel is a fair representation of my art therapy practice. I'd like to show you this and audio-record our discussion of it when we meet in the focus group. In preparation for the meeting, I wonder if you could have a look at the two 8 minute films on the DVD (enclosed) before we meet. This will play on an ordinary computer in windows media player – it automatically comes up when you put the DVD in. Both films are of the same segment of an art therapy group, one is a film of the people in the group and the other is an AIR. I've asked you to look at both because in art therapy there is too much to look at in one go: if you look at the image you miss the group interaction and *vice versa*. Please do not make a copy of the DVDs. I will collect these back at the focus group so please bring them along. When you look at the films I'd like you to start generally thinking about how you would describe: what you are seeing; any therapy element or process you perceive to be active; and any kind of change in any of the participants. When doing this please do not feel that you need to use highly academic terms, just your ordinary thoughts would be great. When we meet we'll look at the films again and have a discussion about them focusing on the above areas. I would like to audio-record this, but can reassure you the recording will be confidential to me and my supervisor. I will be making a written transcript of the recording but will ensure you are in no way identifiable.'

Neil Springham

Consultant art therapist

Appendix E
Thematic Codings for Feasibility study.

Artist increases personal connection to own artwork through others' comments on it.	**Therapist primarily encourages verbalisation of group members' associations to artist artwork**	**Emotional link did not always exists between image and artist prior to discussion**	**Finding similarities between artworks in the group lessens anxiety for artist**	**Discussion of artists artwork connects group member emotionally to artist**	**Finding links between group members without images is important as a second step**	**Verbalisation of artwork content aids emotional control for artist**
M: yes... there was a sharing of experiences and clearly the way the two people who hadn't made the image, erm... seemed to have quite a big influence on the way the art-mak*er* then saw her own piece of art-work. L: for me it was also more about erm, ... it was that but it was also trying to compare different thoughts I suppose and feed those thoughts back to different people in the group, so, and encouraging as well at the point where Maria said she didn't know what she thought about the mystery bit but she liked it ... it was just probing that to make her think why she liked it, it was more probing then thinking about that with the others. So it was different perspectives juggling backwards and forwards ... I thought... and that was the job of the therapist, as you say to contain that and make that apparent because I think that can happen in a conversation and it will just dissipate but actually the therapist was making it very apparent and clear that was happening. I think that is the therapist's role. M: they seemed to be looking at the image a lot and um, not only telling the other what they saw but, sort of um, some of their	M: and the focus was very much on the image ... there was little, I think, ... talk about other things. M: I suppose I was expecting to talk about their picture. Because three people had pictures in front of them and I guess it was quickly... it fairly soon emerged that you were leading the group in some way. M: the therapist seemed to be ... um ... structuring the discussion took place ... um ... to some extent ... and ... asking questions .... and erm, trying to facilitate the discussion, and I guess containing that in some way. K: Yeah I think I noticed there were I think two examples where the therapist was trying to make more explicit erm, a kind of an emotion that was very clear but there was also some kind of uncomfortableness about that and I think there might have been some humour used at some point which seemed to diffuse it a bit and kind of relax the situation a bit and enable a bit more to be said. K: I suppose it's, thinking about it now that it strikes	K: I suppose I was surprised at the emotion, I think that came out. And I think that was a bit how it felt to Maria, it sounded like she was quite surprised by what happened, that she had somehow expected to be a bit more detached from it. And I think I was perhaps having the same experience of expecting it to be, I don't know, a bit more intellectual in a way, where as there was a real process, a real emotional happening there and you know, being able to process that ... the way that the group processed it and I suppose we were processing it at second hand ... it.. It did seem there was an awful lot going on, it was very rich. K: I suppose I keep thing about the image itself and how a little bit, at first it was distracting, at first it seemed to be one way up in the actual group setting with the black bar to one side and when we saw the image on its own we saw the black bar with the base of the image. But then I though what	K: I felt they were finding a language for the artwork and their comments were very different and it seemed that they were, I don't know, like you said, picking up that she did feel quite uncomfortable that she wasn't saying very much in the very early part of the film. And it seemed they were trying to find the words, not the words *for* her but trying to find some words describe her image and that seemed to help her to talk about her experience of doing it. K: I noticed that Julie linked a colour and a shape in her image to a similar one in Maria's and there seemed to be something about the way they both felt about the workshop. I did wonder if there was some relief in sharing that anxiety about the workshop and erm	L: yeah I thought that worked, that people also were quite free with some of their own associations with it, with the image, which ... didn't feel... I mean at the end she said something about feeling exposed it didn't feel '*exposing'*. The things they were saying... they were very much kind of their own. K... they owned them didn't they... L: yeah... they weren't putting them onto her. I thought that was good. L: I think I would say it's a film about therapeutic, about art therapy intervention showing how it can erm, sort of change, show different perspectives and different ... how people can get different erm feelings and thoughts from an image ... and share those L: I think I felt that Maria ... erm, did still quite exposed at the end and I think it was really interesting that she enjoyed others comments, and she found them interesting, but she had emotional baggage with the image that was maybe to do with	K: I think I was struck by the sort of gentleness of the way that people were talking and...Um... it seemed to kind of.... allow Maria to... you know, either sort of say... or to either not say very much or as it went on to say a bit more. It's quite a small group. L: I think it was partly a sort of dipping in and a dipping out. Being able to think about the image in terms of their stuff but also thinking about it from Maria's point of view and maybe thinking about what it would be if I was in that position. I thought there was quite a lot of empathy, possibly, informing how they were with her. K: I noticed the change in Maria, I thought that she seemed quite erm, not exactly withdrawn, but everything seemed quite bottled up at the beginning. Erm ... and then towards the end there seemed to be a kind of relaxation and she seemed more able to tell people that she had had a difficult day and her feelings about doing the workshop and her feelings being exposed and she was able to *say* that she felt vulnerable I suppose, whereas before she was just *vulnerable*, or seemed in the beginning and the artwork had a big part to play in that. So that	K: I suppose I would sort of add that it was a non-verbal, what happened was a non-verbal process and it seemed as the film went on that it did relate to the way Maria was feeling but it wasn't easy for her to kind of notice that immediately and it was only through the process of talking about the artwork that it seemed to help her make sense of it and she became more verbal as... after she had had that feedback and reflection from other people. K: well it seemed for two of them that it had felt anxiety provoking to be coming to do the workshop ... erm ... and the person who talked about her artwork, it seemed that it was ... she was able to process that in some way in the workshop, her feelings about doing it ... and I think the other two were trying to be just very honest and ... helpful I guess. Not having seen the rest of it I can't really comment on anymore. K: she seemed to kind of make more sense, it was something about making more sense of the image that seemed to help her to ... that it wasn't a mess, there was something about it having some meaning. L: I think its therapeutic because its saying something that was un-said inside her and she maybe hadn't even verbalised it herself and sometimes if you can say that out loud then it kind of helps make sense of what you were feeling' she might have felt what she was feeling was quite, what you said, inhibiting 'bottled up' but because she could say it she visibly seemed to relax a bit more. So I think that was a therapeutic intervention M: mmm ... I'm probably saying the same thing here but the other thing I was mostly struck by was how talking about an image um, seemed to

associations with that, some of their ... um, connections with the outside world, some of their connections with their own thoughts and feelings which then seemed to be shared in some way or at least the person who made the image could connect with and that then seemed to change the way she felt about having made it and it seemed to also ... yes I suppose that person seemed to be the person who was expressing more feeling, there was more of a subjective kind of mood connected with it or it was more intense maybe, but it moderated having had the other people look at it and give their own version of the way they saw it. M: yes, at the... they seemed to be trying to relate to her through the artwork, to put it in a short phrase, they made some sort of connection with the image which seemed to then make some connection then with her.	me that there is a real emphasis on getting the group to do the work, rather than the therapist, reflecting back and putting things into words, it was very much about getting the group to do that. That makes me think how different that would be in an individual session. So... yeah it just struck me the nature of the group work.	Maria had actually said that it moved around as she made it and in fact when it was shown on its own I kept getting the feeling that it was very internal and Brian was talking about it being a seascape but I felt it was very internal like somewhere trying to find a way out of somewhere but again that might have been influenced by what was said about it and the process. K: and I thought it really struck me that how rich the image is and how much ambiguity there is and the potential for people to see different things and make different senses of it...	and I think Brian just quite enjoyed, I don't know if fatherly is quite the right word, but he was quite, very kind and I felt he quite enjoyed that, that he had that sort of role a bit. M: well I think it must be some evidence of relating and um and if , if the .... this activity can promote relating and understanding between people then that's quite a major part of what that's to do with	the situation and you know, and the filming: feelings of being exposed and I felt the other two were a little more protected from being exposed, certainly in the excerpt we saw. They weren't showing their artwork or talking about it, but I think they were very sensitive with that and the way they spoke to her. K: I noticed the change in Maria, I thought that she seemed quite erm, not exactly withdrawn, but everything seemed quite bottled up at the beginning. Erm ... and then towards the end there seemed to be a kind of relaxation and she seemed more able to tell people that she had had a difficult day and her feelings about doing the workshop and her feelings being exposed and she was able to *say* that she felt vulnerable I suppose, whereas before she was just *vulnerable*, or seemed in the beginning and the artwork had a big part to play in that. So that seemed, that seemed very therapeutic for her although it didn't seem entirely comfortable. L: yeah, but it enabled her to say it, didn't it I suppose, the group experience helped her to be able to verbalise it.	seemed, that seemed very therapeutic for her although it didn't seem entirely comfortable. L: yeah, but it enabled her to say it, didn't it I suppose, the group experience helped her to be able to verbalise it. eemed more open, she seemed to open up to her own experience a bit more and she must have opened herself up to the other's comments as well and actually internalise and then there was a general lessening of tension in the group as a whole M: I thought that what seemed to take place a connecting between people and I think that's a useful thing to happen in a group. M: yes they get in touch with something or another person with the artwork or the whole process and that enables something of that to happen and they will be maybe more in touch with themselves.	kind of free up the person who seemed to bring potential anxiety about having made the image into the group changed. So it wasn't like directly talking about the anxiety, or where that may have come from, but it was the focus on the way people saw the image that seemed to make that come about. L: I suppose I was left with the thoughts about the accidents and the chaos went into making the image and when it was talked about it didn't seem like that was there anymore. It was kind of around the making of it and then what was around in the day, you know the day that Maria came to the workshop, but that it didn't feel it was in the image so much, I don't know, the finished product. I suppose it was similar to what you were saying about anxiety... how that was around in the making of it but it sort of dissipated in the discussion or became something else, it became something that could be verbalised but then felt less uncontrollable and chaotic and a bit more ... K: so it sort of transformed and contained.... L: Yeah a bit more under Maria's control and a bit more understandable L: no because making the image was an unfamiliar experience even though she was using familiar materials and she spilt the water and she didn't want the black on the brush and suddenly it was there, so it was all very random things happening which made her feel quite out of control and came into the feeling of feeling quite exposed and getting it wrong and all that stuff and then through talking about it as you've said the anxiety kind of went to a different place and was able to verbalise that and feel a bit more in control of things because she was ... she had used the artwork to express it.

Appendix F
Formal Ethics tabl

NHS
Health Research Authority

NRES Committee London - Bromley
South West REC Centre
Whitefriars
Level 3, Block B
Lewins Mead
Bristol
BS1 2NT

Telephone: 01173421386
Facsimile: 01173420445

01 February 2012

Mr Neil Springham
Head of Art Therapy
Oxleas NHS Foundation Trust
63 Croydon Road,
Penge,
London
SE20 7TS

Dear Mr Springham,

Study title: **Mentalization in the art therapy triangular relationship: How do art therapists interact verbally with service users and their visual images in art therapy groups aimed at treating people with personality disorder?**

REC reference: **12/LO/0065**

The Research Ethics Committee reviewed the above application at the meeting held on 19 January 2012. Thank you for attending to discuss the study.

Ethical opinion

- The Committee agreed that it was not clear as to what were you trying to research through this study. The Committee asked you as to what are you trying to look at through this research, is it the art therapists, the patients/users or the art. You explained that the study looks at the overall relationship between art, the therapist and the users. You further explained that the study primarily looks at the art therapists and how they use the mentalization for therapy.

- The Committee noted that the research is to be based on three art therapists chosen by you and raised concern about the outcome of research if three bad/unsuitable art therapists were chosen for this research. You clarified that art therapists will be chosen after careful consideration, but if for some reason the chosen therapists are not as they are expected to be, then the research will show us.

- The Committee asked you if the study would involve setting the art therapists against set criteria. You confirmed that the therapists would indeed be evaluated against set criteria. You further explained that since not much is researched and known about this field, this study would provide an opportunity to understand this field a bit better and even help set a benchmark or a code of practice to help art therapists in future.

- The Committee asked you if there would be any reputational risks to the art

therapists in case they do not comply with the set standards. You explained that in your view there would not be any reputational risks as this is a very new field, if at all this would only benefit them.

- The Committee raised its concerns about the safety of the service users and asked you if they would be watching their own videos. You confirmed that none of the service users would be watching their own videos.

- The Committee raised its concerns about the "stable long term" patients. The Committee asked you as to what assurances the Committee have that these patients will not be harmed in long term and also about the selection of these patients. You explained that all the patients will be selected through "Emergence". They are working at Emergence as staff members and are all stable. A letter could be provided to the Committee to reassure that they are not service users anymore.

- The Committee asked you if there could be a possibility that these prospective participants might have been cleared earlier but their circumstances might have changed. You explained that the Emergence has been set up by the government and they are very experienced in this, and therefore the likelihood of that happening is very less. Moreover, they also have a process to manage such situations. The Committee however stated that it would be better if the participants have a consultation with a professional before taking part in this research. You agreed to find out more about this point and get back to the committee in your response.

- The Committee asked you if consent will be taken from the service users for video and audio recordings. You explained that the trusts have their own process for taking Consent. However, we are asking for extra consent to have extra audience to look at that. The Committee however pointed out that the consent form submitted, does not mention anything about "recording", it only mentions "viewing". You agreed to follow the committee's advice to amend the consent form and submit with your response.

- The Committee asked you if it would be possible to pixelate the videos to protect the identity of the participants. You explained that since you would need to study the details like expressions and body language of the participants, it would not be possible to do so.

- The Committee asked you that in case the therapists select the service user they have to record, could there be chances of coercion. You explained that there would be no special videos recorded for this study. The research will make use of previously recorded videos of the treatment already done. No new/special sessions will be set up for the purpose of this research. Segments will be chosen from previously recorded videos and if a service user does not agree, their video will not be used.

- The Committee asked you that since videos are raw data, should they not be kept for upto 10years. The Committee also queried as to what researchers plan to do with the personal information like names and other details. You agreed to keep the videos for upto 10 years and confirmed that you will not be collecting any personal information during this research. The Committee further queried that the Patient Information Sheet states that the videos will be destroyed after the research is over. You agreed that it is a mistake and you will amend and submit revised PIS.

- The Committee asked you if the Consent Form for focus groups should also state about the videos. You agreed to include the same and submit revised Consent Form.

Sponsors are not required to notify the Committee of approvals from host organisations

It is responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

You should notify the REC in writing once all conditions have been met (except for site approvals from host organisations) and provide copies of any revised documentation with updated version numbers. Confirmation should also be provided to host organisations together with relevant documentation

Approved documents

The documents reviewed and approved at the meeting were:

Document	*Version*	*Date*
(None)		03 January 2022
Evidence of insurance or indemnity		
Investigator CV	Neil Springham	
Investigator CV	Paul Camic	
Other: Data Protection Guidance and Protocol for Research	1	01 August 2011
Other: Email from Lou Gordon		29 September 2011
Participant Consent Form: Art Therapists	1	01 August 2011
Participant Consent Form: Att Therapists Group Member Research	1	01 August 2011
Participant Consent Form: Art Therapy Research Focus Group	1	01 August 2011
Participant Information Sheet: Information for Art Therapists	1	01 August 2011
Participant Information Sheet: Focus Group Participant	1	01 August 2011
Participant Information Sheet: Information for Group members	1	01 August 2011
Protocol	1	01 August 2011
REC application	3.2	08 December 2011

Membership of the Committee

The members of the Ethics Committee who were present at the meeting are listed on the attached sheet.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Reporting requirements

The attached document "After ethical review – guidance for researchers" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol

- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

Feedback

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

Further information is available at National Research Ethics Service website > After Review

12/LO/0065	**Please quote this number on all correspondence**

With the Committee's best wishes for the success of this project

Yours sincerely,

pp Ms Carol Jones
Chair

Email: Ubh-tr.CityandEastREC@nhs.net

Enclosures: *List of names and professions of members who were present at the meeting and those who submitted written comments*

"After ethical review – guidance for researchers"

Copy to: *Paul Camic, Canterbury Christ Church University*

Anthony Davis, Oxleas NHS Foundation Trust

NRES Committee London - Bromley

Attendance at Committee meeting on 19 January 2012

Committee Members:

Name	*Profession*	*Present*	*Notes*
Mr Munir Ahmed	Consultant Urologist	No	
Mrs Susan Beer	Retired Project Manager	No	
Mrs Angela Clayton-Turner	Retired NHS Therapy Manager	Yes	
Ms Carol Jones	Management Consultant	Yes	
Mrs Kathryn Kinnear	Solicitor	Yes	
Mrs Fran McMillan	Retired	Yes	
Rev Tim Mercer	Hospital Chaplain	No	
Dr Angela Orunta	Consultant Anaesthetist	Yes	
Dr David Osoba	Staff Community Paediatrician	No	
Mr C.V. Praveen	Associate Specialist in ENT	Yes	
Mrs Christine Rumbelow	Retired Charity Organiser	No	
Dr Mukesh Sahi	General Practitioner	Yes	
Ms Jayne Steadman	Consultant Physiotherapist	Yes	

Also in attendance:

Name	*Position (or reason for attending)*
Mr Rajat Khullar	Committee Coordinator

Assurance regarding Service user Focus Group

Information received from Emergence concerning the points required by the Research Ethics Committee:

"In terms of what assurances of confidentiality and minimising any potential for harm among service user participants, what I would suggest is the following:

All staff and volunteers who work with Emergence sign up to our data protection and confidentiality policy which includes the provision of training in these areas. We would involve only people who also have other roles within the organisation where commitment to confidentiality has been demonstrated and management of this and related issues is central to their role. Similarly all staff and volunteers for Emergence go through a rigorous recruitment process which explores readiness for work and ensures people have coping skills to manage their own responses to difficult material. We operate on a principle of self management with support as appropriate so people are well used to weighing up whether they are currently well enough to undertake a specific task and we have a strong organisational culture of open discussion about difficulties affecting anyone's work. All individuals we would involve in this project already hold significant responsibilities which they manage well. All of their roles expose them to material which is potentially triggering and all have coping strategies for managing this and are well able to judge for themselves whether this is an appropriate activity for them at any particular time.

In principle we don't do CRB checks across the board unless specifically needed for a role and it would really slow things down and add to costs to try to get them for this project. However we can ask each person to provide a CV which will demonstrate that for all dealing with confidentiality and sensitive, potentially triggering information is a routine part of their work. Emergence as an organisation can offer

assurances that the individuals selected for participation are well aware of and respectful of confidentiality. We have extensive indemnity insurance to cover any issues which could arise, but this is highly unlikely in this piece of work. We can also offer telephone support after the focus group if anyone is affected by the material in the videos. In addition since they will all be members of staff they will all have access to supervision and we can highlight to them that if they feel they need to, they can discuss their response to taking part within their usual supervision structures if necessary."

(Morgan 29/09/2011 personal correspondence)

Health Research Authority

NRES Committee London - Bromley
South West REC Centre
Whitefriars
Level 3, Block B
Lewins Mead
Bristol
BS1 2NT

Telephone:0117 342 1387
Facsimile: 0117 342 0445

27 April 2012

Mr Neil Springham
Head of Art Therapy
Oxleas NHS Foundation Trust
63 Croydon Road,
Penge,
London
SE20 7TS

Dear Mr Springham

Full title of study: **Mentalization in the art therapy triangular relationship: How do art therapists interact verbally with service users and their visual images in art therapy groups aimed at treating people with personality disorder?**

REC reference number: **12/LO/0065**

Thank you for your letter of . I can confirm the REC has received the documents listed below as evidence of compliance with the approval conditions detailed in our letter dated 19 January 2012. Please note these documents are for information only and have not been reviewed by the committee.

Documents received

The documents received were as follows:

Document	*Version*	*Date*
Covering Letter		10 February 2012
Participant Consent Form: Consent Form for Art Therapist	2	01 February 2012
Participant Consent Form: Consent form for Art Therapy Group Member	2	01 February 2012
Participant Consent Form: Consent Form for Focus Group Member	2	01 February 2012
Participant Information Sheet: Information Sheet for Art Therapist	2	01 February 2012
Participant Information Sheet: Information Sheet for Art Therapy Group Member	2	01 February 2012
Participant Information Sheet: Information Sheet for Focus Group Member	2	01 February 2012

You should ensure that the sponsor has a copy of the final documentation for the study. It is the sponsor's responsibility to ensure that the documentation is made available to R&D offices at all participating sites.

NHS
Health Research Authority

12/LO/0065 Please quote this number on all correspondence

Yours sincerely

Miss Vicky Canfield
Assistant Committee Co-ordinator

E-mail: ubh-tr.BromleyREC@nhs.net

Copy to: *Paul Camic, Canterbury Christ Church University*
Anthony Davis, Oxleas NHS Foundation Trust

Appendix G
Art Therapy Group Member Information Leaflet
Study Name: Mentalization in the Art Therapy Triangular Relationship

How do art therapists interact verbally with service users and their images in art therapy groups aimed at treating people with personality disorder?

Part 1: I would like to invite you to take part in this research study as part of my PhD. Before you decide I would like you to understand why the research is being done and what it would involve for you. I will go through the information sheet with you and answer any questions you have. I'd suggest this should take about 15 minutes

What is the research about?
The research project involves videoing art therapy groups. By looking closely at what art therapists do the aim to improve how art therapy works so it can help people better. This is a much better method of assessing what art therapists do than just asking them to describe their work.

Who is doing the research?
Neil Springham is a consultant art therapist at Oxleas NHS Foundation Trust and this research is part of a PHD at Canterbury Christ Church University.

Why have I been asked to take part?
The focus of the research is very much on what the art therapist does, but because this is your group your art therapist will only use video recording if they have your permission first.

Do I have to take part?
No. It's entirely voluntary and it's not a problem if you don't want to. Not taking part, or withdrawing once you have started, will not affect your current or future care in anyway.

What does taking part involve?
I would like to use a 15 minute video clip of an art therapy session to look at how the art therapist talks to the group about an art work. This video clip is viewed by three different focus groups:

1. A group of 5 art therapists from the British Association of Art Therapists
2. A group of 5 different types of psychological therapists from Oxleas NHS Foundation Trust
3. A group of 5 Experts by experience from Emergence + (*Experts by experience are researchers who have had experience of using mental health services. Emergence is a*

service user led organisation for people who have a diagnosis of Personality Disorder. They are committed to improving services for and understanding of the condition. For more information on: www.emergenceplus.org.uk)
These focus groups will try to understand what the art therapist is attempting to do.

Part 2: How will my confidentiality be protected?
The data protection process has been approved by NHS research ethics number 12/LO/0065

- All participants in the focus group will sign that they will adhere to strict data protection protocol
- All recordings will be held on NHS security encrypted devises.
- No record of your name or anything that can identify you will be kept
- All focus groups will be held in strict confidence.
- All data will be destroyed 10 years after the end of the study in 2014.

Are there any advantages or disadvantages to taking part in the research?
Nothing will change in your treatment and your GP will not be informed. It may feel a little strange at first to have recordings shown to other people, but all of these will be carefully checked and most patients tell us that they are not worried by this once this has been explained.
Having your therapist filmed can bring benefits as we can improve what they do in treatment. In the main though, you will be greatly helping to improve the quality of art therapy so that it can help others who have similar difficulties.

What happens to the research?
This will be written up as my PhD but if you would like I will send you a short report telling you what I found out in the research. I will publish the results but your name or any other personal identifier will be completely removed.

If there are problems I can be contacted on:
neil.springham@oxleas.nhs.uk
Tel: 07733314717
In addition you can speak to your care team if there is anything you are unhappy about in the research

The Study is covered by Indemnity Insurance at Canterbury Christ Church University. If there are any complaints you can contact the Chief Investigator, Neil Springham on the above or his Supervisor Professor Paul Camic at Canterbury Christ Church University on 01892 507773

Many Thanks for considering this research

Neil Springham.

Appendix H
Information Sheet for Art Therapists

Study Name: Mentalization in the Art Therapy Triangular Relationship

How do art therapists interact verbally with service users and their images in art therapy groups aimed at treating people with personality disorder?

Part 1: I would like to invite you to take part in this research study as part of my PhD. Before you decide I would like you to understand why the research is being done and what it would involve for you. I will go through the information sheet with you and answer any questions you have. I'd suggest this should take about 15 minutes

What is the Study About?
The aim is to generate a practice description of how art therapists interact with patients and their images. This involves showing a film clip three different art therapists viewed by three different focus groups:

4. A group of art therapists (you included)
5. A group of different types of psychological therapists from Oxleas NHS Foundation Trust
6. Experts by experience from Emergence

These focus groups will try to understand what the art therapist is attempting to do.

Do I have to take part in the study?
No, it is entirely up to you. If you wish to withdraw during the study this is not a problem, all your data will be destroyed.

Pt 2: How will I get consent from the patients I work with?
I will provide you with consent forms and take you through the protocol (as outlined below)

What Data will be collected on me or those I am responsible for?
Only the 15 minute video that you select will be collected. No other information such as names, addresses, or dates of birth etc will be collected.

How will the data I collect be protected?
The data you give me will be stored in compliance with the data protection act 1988. No one else will have access to it. All data will be destroyed 10 years after the end of the study in 2014.
The Study has been approved by 12/LO/0065 Research Ethics Committee.

How to select a video edit.
I would like you to choose a 10 – 15 part of a group where you feel you were talking to the patient in the group about their art work (the triangular relationship) in a therapeutic way. We have very little

theory to guide us as art therapists on this so I would like you to use your own judgement.

If there are problems I can be contacted on:
neil.springham@oxleas.nhs.uk
Tel: 07733314717

The Study is covered by Indemnity Insurance at Canterbury Christ Church University. If there are any complaints you can contact the Chief Investigator, Neil Springham on the above or his Supervisor Professor Paul Camic at Canterbury Christ Church University on 01892 507773

Gaining Informed Consent from your group members
You will need to obtain informed consent from your patients. This information leaflet gives you guidance for this purpose.

Data Protection

Because the research involves film of service users we will need to adhere to a strict data protection policy to maintain confidentiality. The guidance here aims to give you a method of handling the data involved in a way that conforms to the data protection act as approved by NHS ethics. The procedure has been drawn up in line with Oxleas NHS foundation Trust policy and legal and ethical guidance from the British Association of Art Therapists (BAAT) and their lawyers Russell, Jones & Walker Solicitors.

Data Guidance for Art Therapists

As art therapists we deal with a great deal of sensitive personal information and in its handling we must follow the guidance in the BAAT code of conduct and ethics (www.baat.org). This is a duty under our registration with the Health professions council. There are specific laws and principles that currently govern confidentiality and these are as follows:

Data Protection Act 1998

The Data Protection Act became law in March 2000. It sets standards that must be satisfied when obtaining, recording, holding, using or disposing of personal data. The Act covers most manual records, e.g. :

Health	Personal	Occupational health	Volunteers
Finance	Suppliers	Contractors	Card Indices

The 8 Data Protection Principles

Personal data must be:

1. Processed fairly and lawfully
2. Processed for specific purposes
3. Adequate, relevant and not excessive
4. Accurate and kept up to date
5. Not kept for longer than necessary
6. Processed in accordance with the rights of data subjects
    - Subject access
    - Prevention of processing
    - Prevent processing for direct marketing
    - Automated decision taking
    - Compensation
    - Rectification/blocking/erasure
    - Request an assessment
7. Protected by appropriate security (practical and organizational)
8. Not transferred outside of the European Economic Area without adequate protection

This means that Art Therapists must

- Inform data subjects why they are collecting their information, what they are going to do with it and whom they may share it with
- Only use personal information for the purpose(s) for which it was obtained
- Only collect and keep the information they require (not ‘just in case it might be useful one day’ e.g. taking

evening telephone number when you will only phone in the day), they must have a view as to how it will be used.
- All abbreviations must be explained
- Take care to have mechanism to ensure the info is accurate and up to date
- Check their organizations retention and disposal policy
- NHS organizations (and other may also) have a designated Data Protection officer
- The Information Commissioner's website: http://www.datprotection.gov.uk

Caldicott

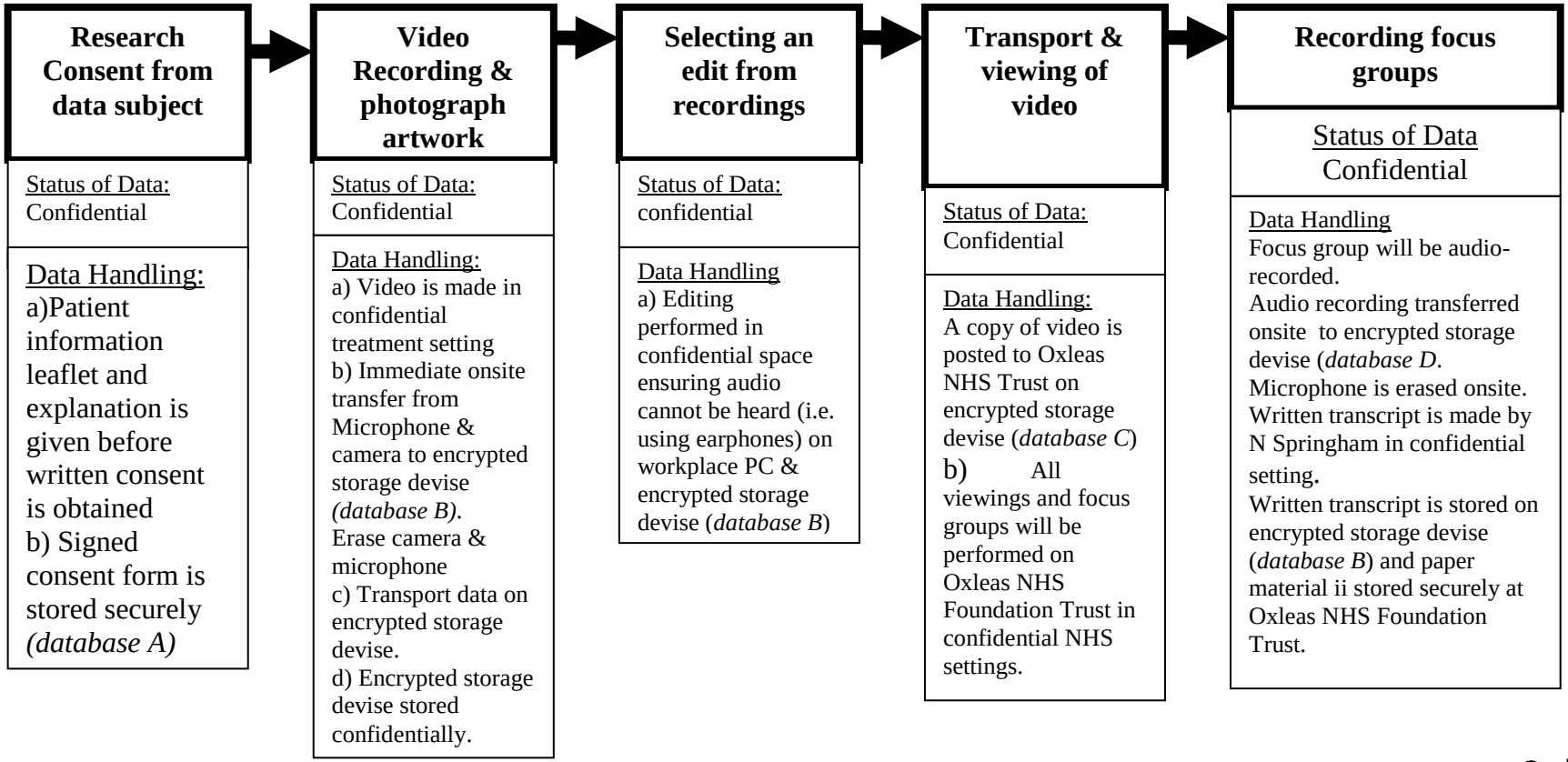
The term 'Caldicott' refers to a review commissioned by the Chief Medical Officer. A review committee, under the chairmanship of Dame Fiona Caldicott, investigated ways in which patient information is used in the NHS. The review committee made recommendations aimed at improving the way the NHS handles and protects patient information. There are six Caldicott Principles:

1. Justify the purpose(s) of using confidential information
2. Only use it when absolutely necessary
3. Use the minimum that is required
4. Access should be on a strict need-to-know basis
5. Everyone must understand his or her responsibilities
6. Understand and comply with the law

The algorithm below describes how data will need to be processed. The Caldicott database that follows that outlines the details of how data will need to be stored etc.

l

Data Protection Protocol



Oxleas NHS
NHS Foundation Trust

Caldicott Database:

NAME OF DATABASE	LOCATION	PURPOSE OF DATABASE	INFORMATION HELD	DATA CUSTODIAN	WHO HAS ACCESS	ACCESS SAFEGUARDS
A: Consent form	Art Therapy office	Consent for research to proceed	Consent details and personal identifiers	Clinically responsible Art Therapist	Clinically responsible Art Therapist	Locked cupboard in locked art therapy office
B: Video recording	Encrypted memory stick or protected work PC	Raw data for Research	Raw data Private details and personal identifiers. Faces and voices.	Clinically responsible Art Therapist	Clinically responsible Art Therapist	Encrypted memory devise or protected work PC
C: Edited Video	Encrypted memory stick or protected work PC	Selected video clip for viewing by focus groups	Faces and Voices. No other private details and personal identifiers.	Clinically responsible Art Therapist & Neil Springham	Clinically responsible Art Therapist	Encrypted memory devise or protected work PC
D: Audio recording of Focus Group	Encrypted memory stick or protected work PC	Data for research analysis	Personal identifiers and voices of focus groups.	Neil Springham	Neil Springham	Encrypted memory devise or protected work PC
E: Written Transcript	Encrypted memory stick or protected work PC and workplace storage	Transfer transcripts to research analysers	Anonymised	Neil Springham	Neil Springham	Encrypted memory devise or protected work PC & locked cupboard in locked art therapy office.

Appendix I
Information for Focus group Participants

Study Name: Mentalization in the Art Therapy Triangular Relationship

Focus Group Information Leaflet

Part 1: I would like to invite you to take part in this research study. Before you decide I would like you to understand why the research is being done and what it would involve for you. I will go through the information sheet with you and answer any questions you have. I'd suggest this should take about 15 minutes

What is the research about?

The research project involves videoing art therapy groups for people who have a diagnosis of personality disorder. Looking closely at how art therapists interact with service users and their images (triangular relationship) can improve how art therapy works.

Who is doing the research? Neil Springham is a consultant art therapist at Oxleas NHS Foundation Trust and this research is part of the PHD at Canterbury Christ Church University. I can be contacted on 07733314717 or neil.springham@oxleas.nhs.uk

Methodology

Sample Size: Three art therapists deliver groups

Selection criteria for art therapists:

- Membership of the British Association of Art Therapists special interest groups on personality disorder (BAAT-SIGPD)
- Additional training in mentalization
- Their group is aimed at treating service users who have diagnosis of personality disorder

Step one

Three art therapists will be asked to self select a 10 – 15 minute film of their art therapy practice. The segment of film shows the art therapist interacting with the service user and their image in a manner that the therapist rates as therapeutic.

Step two

The three films will be viewed by three separate focus groups:

1. Experts by experience from Emergence
2. Art therapists from the BAAT SIG PD
3. A selection of psychological therapists trained in Mentalization from Oxleas NHS Foundation Trust

Practice descriptions will be sought from these focus groups. Each group will be asked:

- How would you describe what is happening here?
- What are the essential characteristics of this?
- What is the therapist attempting to do?
- What is therapeutic about this?

Analysis of Focus groups is by Grounded Theory

Do I have to take part in the study?

No, it is entirely up to you. If you wish to withdraw during the study this is not a problem, all your data will be destroyed.

Part 2: The study will require you to attend one three hour focus group.

How is confidentiality managed?
Your data and the data you will see is processed under strict protocol. You will need to keep the information you see confidential. Your data will likewise be protected. The data protection process has been approved by NHS research ethics 12/LO/0065.

- All recordings will be held on NHS security encrypted devises and destroyed after the research is finished.
- All focus groups will be held in strict confidence.
- You can decide if you wish to be identified in the study

The data you give me will be stored in compliance with the data protection act 1988. No one else will have access to it. All data will be destroyed 10 years after the end of the study in 2014.

The Study is covered by Indemnity Insurance at Canterbury Christ Church University. If there are any complaints you can contact the Chief Investigator, Neil Springham on the above or his Supervisor Professor Paul Camic at Canterbury Christ Church University on 01892 507773

Appendix J

Consent forms

Art Therapy Group Member
CONSENT FORM

Title of Project: **Mentalization in the Art therapy Triangular relationship**

Name of Researcher: **Neil Springham**

Please initial box

1. I confirm that I have read and understand the information sheet dated August 2011 (version 1) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected. ☐

3. I understand that relevant sections of audio-video recordings collected during the study may be looked at by the chief Investigator and his academic supervisors at Canterbury Christ Church University and Oxleas NHS foundation Trust, British Association of Art Therapists and Emergence + staff where it is relevant to my taking part in this research. I give permission for these individuals to have access to my video recordings. ☐

4. I agree to take part in the above study. ☐

Name of Patient	Date	Signature
_____	_____	_____

Art Therapist
CONSENT FORM

Title of Project: **Mentalization in the Art Therapy Triangular Relationship (ethics ref 12/LO/0065)**

Name of Researcher: **Neil Springham**

Please initial box

1. I confirm that I have read and understand the information sheet dated August 2011 (version 1) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected. ☐

3. I understand that relevant sections of audio-video recording collected during the study, may be viewed by the chief Investigator and his academic supervisors at Canterbury Christ Church University and Oxleas NHS foundation Trust, British Association of Art Therapists and Emergence + staff, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my recordings. ☐

4. I agree to abide by the data protection protocol for this study ☐

5. I agree to take part in the above study. ☐

Name of Participant	Date	Signature
_____	_____	_____

Focus Group
CONSENT FORM

Title of Project: **Mentalization in the Art Therapy Triangular Relationship (ethics ref: 12/LO/0065)**

Name of Researcher: **Neil Springham**

Please initial box

1. I confirm that I have read and understand the information sheet dated (version 1 August 2011) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason. ☐

3. I understand that relevant sections of transcripts from audio recordings collected during the focus group be viewed by the chief Investigator and his academic supervisors at Canterbury Christ Church University where it is relevant to my taking part in this research. I give permission for these individuals to have access to my transcript. ☐

4. I agree to abide by the data protection protocol for this study ☐

5. I agree to take part in the above study. ☐

Name of Participant Date
Signature

Appendix K

Example of Transcript from the Treating Art Therapists Group Showing how I did not Speak Until after Other Focus Group Members Spoke.

Treating art therapist focus group one

FOCUS GROUP MODERATOR: Ok, any thoughts or impressions?

PARTCIPANT 1: well I have obviously seen it before. I am really aware of my body posture at the time. That was my immediate reaction to seeing it is to see how I was holding myself. I think I am certainly speaking louder ... I don't know if that was a consciousness of being filmed. I think the immediate thing I am struck by is there was about whether the whole group felt included in the discussion they were two members who don't talk throughout the whole clip ... so I think now that is something that I feel more aware of, you know wondering where their minds were, what they were thinking

FOCUS GROUP MODERATOR: I am putting this in the third person, which might seem a bit strange, but I think there is quite a useful question there about what were the therapists intentions and how does the fact that three people spoke and two didn't fit in with that or not? If I am asking people who were not involved in that I am asking them from what do you see? What does it look like? What do you think the therapist was trying to achieve?

PARTCIPANT 2: I suppose I was wondering about ... where ... I was thinking about how you are trying to develop a narrative about this picture without actually ... it's a tricky balancing act of being curious about the image without laying some breadcrumbs down. Because as I look at this picture even now I have got lots of thoughts "ooo is this a split mind?" and I can see that actually you were quite tentative with the art-maker and I was thinking about mentalization theory and it is all about thinking ...

PARTCIPANT 1: mmm, mmm

PARTCIPANT 2: and I am just wondering was that something that was in your mind at that point?

PARTCIPANT 1: Yeah, well if I cast my mind back to this particular patient I think he is very erm, cerebral and gets very caught in thoughts and cognitions and I think trying to help him think about the feeling side of his experience is something that in the time he has been with us we have increasingly been trying to do and I think what was, if I am looking at the video and recalling my experience, was that he was very stuck with the idea that he didn't know what to do, and he only appears to make slight shifts in erm, being able, I think to explain or give some understanding to what perhaps was causing that experience he does eventually describe a feeling of frustration, I think that was the only snippet of the feelings that I got from him so I think that was very much in my mind about what I was trying to erm, the intention behind my questions was to try and make a bit of sense of what was contributing to this problem today which was "coming to art therapy and don't know what to do." So I think it probably to my mind is very small baby steps to try and help him think about what might be causing that experience that morning, not to go particularly further back from that. We will also then eventually get to the fact that he feels quite kind of self-conscious about people perceive his image and that then becomes something other members can relate to and I thought quite spontaneously they offered their own, well one woman talked about quite a similar experience

PARTCIPANT 2: I think that was quite a validating thing. And it was also ... and I was thinking also about, the individual (art maker) and the group ... seeing the other pictures and thinking they are trying to mentalize the group an early developmental stage in the

group where they were all trying to work each other out in some way but not be too overwhelmed by it, the experience of being together and working each other out

PARTCIPANT 1: mmm yeah

PARTCIPANT 2: although I am not sure where you are with this group, at the beginning stage or not ... it seemed at a developmental stage where the group was at ... introducing others to including others thinking and responses

PARTCIPANT 1: well I work in a slow open model and I can't remember quite what stage in the life of a group they were but erm, ... I think my colleague asked about what other group members feel and I think I might have said something similar. It is often in my mind to try to include other people's responses and as I say the first thing I notice was when I look at that was the two members who didn't say anything

FOCUS GROUP MODERATOR: do you have any more thoughts about that?

PARTCIPANT 1: erm ... I think it was probably something to do with the fact that he seemed to be rather stuck with this idea of knowing what to do. Thinking about it now ... I want to say paralysing, but I don't think I recall feeling paralysed in that session, but just that it was quite slow going and I think perhaps as a therapist I might have got rather preoccupied with that and that might have slightly perhaps might have slightly lost sight of trying to include everyone in this process of elaborating could be contributing to this state of mind

PARTCIPANT 2: did you feel lost?

PARTCIPANT 1: erm no, I mean I thought, I mean what the point where he said something about feeling nothing and I pointed out to him he had actually produced something so I thought there was a bit of disparity in perhaps what his subjective experience was and well what I was seeing was in fact he made two piece of artwork

because in some ways he had done quite a lot, so this feeling that he hadn't done something there was his artwork which we ...

PARTCIPANT 2: you could comment on ...

PARTCIPANT 1: yeah

NEIL SPRINGHAM: I had thought that as l I was watching it and thinking that but if you spent too much time trying to get the non-talking members to talk then it would take something away from the guy whose image it was and it seemed like there was a turn taking process so that eventually we would come round to the silent guys

PARTCIPANT 1: mmm

NEIL SPRINGHAM: and everyone would be put in a different position.

PARTCIPANT 1: mmm

NEIL SPRINGHAM: and I noticed that the art therapist glanced across; there was a lot of glancing across. They were obviously in your mind. There was an open invitation. I also thought that this, erm ... I see what you mean about paralysis, it was almost like he offered this thing saying "here is something that has made me fail at therapy already" and it seemed like a lot of the effort of the art therapist was to sort of say "actually no, that can be in what we look at in the therapy"

PARTCIPANT 1: mmm, mmm, yeah

NEIL SPRINGHAM: and he was, you know, this also can be mentalized. That seemed quite, you know, I would image that he looked like he hadn't really thought of that, you know that the rest of the time was spent apologising like "I am not getting something right" and just trying to apply some light weight curiosity to that which seemed to be a kind of curiosity that went onto ... a lot of people make very certain statements and just

trying to say “actually we can bring that into the lens” seemed to be something you were doing quite a lot I thought

PARTCIPANT 1: mmm, yeah I mean I think there was a sense I got from the image that there was a bit of an imperative that he should be doing something, he should be able to produce a work of art and I think my ... what was in my mind was that he had produced a work of art, and what does this thing that he has produced tell us about internally where he was

NEIL SPRINGHAM: yeah

PARTCIPANT 1: exactly, yeah. But I think it was that feeling he should be able to do something and the fear of judgement was the thing that the other members spontaneously, the ones who could relate to it then offered and didn’t need to be asked so they were quite kind of forthcoming about that

NEIL SPRINGHAM: It does seem that ... I wonder how different it is for a verbal group or an art therapy group that a lot of the patients experience is of listening and watching, not just that person but other people, a lot of the time seems to be listening and watching and I wonder if that really is different in verbal group? Which I think is valuable.

PARTCIPANT 2: I was thinking it’s about seeing ... that consistently being directed at people’s work and the art makers picture there was ... that was going on erm, ... I think it was marked, and if they commented ... there was a sense of the group, the pictures helping them structure the way the conversation goes if that makes sense ...

FOCUS GROUP MODERATOR: isn’t there an important interaction with another image as well and its process and I was wondering if you had thoughts about that? I am thinking of the image made by the guy that had his back to the camera which seemed quite significant interactions around that but also around that process of making it ...

PARTCIPANT 1: yeah, he sort of becomes the object of the capable artist I think to other members and what becomes apparent is that doesn't match how he thinks about himself erm and I make a point of trying to spell that out erm, he says it's obvious and then I say to the two group members who had spoken that it didn't seem that obvious to them erm, ...

PARTCIPANT 2: I think that is the client is also checking out but also that you're monitoring of the responses of others just observing

FOCUS GROUP MODERATOR: and there was something that you said about the experience of making in the context of the dynamics of the group or the interactions in the group as well. It's not quite clear to me, it is one of the two or a mixture of the two and I was wondering if you had any thoughts about that?

PARTCIPANT 2: there was something about that interchange in that part of the group where I did wonder if it was about something else that was going on or what was being communicated which was about having some feeling in the room which and they were talking about, but was there a sense of there was another layer to that communication which was hard to articulate about how they think about feelings ... which I am not sure the group was ready to talk about or whether that then would increase the art makers confusion or frustration perhaps

NEIL SPRINGHAM: mmm, its interesting, because it seemed like the art therapist, the person who started with the art, that became the centre of gravity and we talked about another work of art and in a way it was still in relation to the first piece of art and I thought it was really by contrast, wasn't it

PARTCIPANT 1: mmm

NEIL SPRINGHAM: there was this thing and I was thinking about what you said that the art structures the conversation. There seemed to be a lot of interpersonal action around

having just made art and then focusing even more on one, but it didn't seem an exclusive focus, it wasn't all about it, like "I am sorry we can't talk about that image because we are talking about this image", that seemed to be something that was allowed to happen but somehow still in the service of the first picture in some way it seemed to me.

FOCUS GROUP MODERATOR: how does that sound to you PARTCIPANT 1?

PARTCIPANT 1: well I think what has increasingly becoming a preoccupation of mine is about how the space gets divided up, gets shared and I think what you are naturally seeing in a group is some people were able to use the space and others who find it easier to remain set back. Erm I think the tension for me is trying to give each piece of artwork a potential opportunity to be worked out and responded to but to allow flexibility if we want to shift the focus to another person's work, erm if it is to contrast to the person who made the original piece we are looking at or to look at similarities but there is that kind of erm, there is that kind of movement, to be so rigid looking at one person's art is to the exclusion of everybody else's but there can be similarities or contrasts, which I think they relate to the similarities that can go on in the mind, similarities of preference , similarities of belief, erm or difference ... so something about that, err yeah, fluidness that I think is quite important for the therapist even if you are focusing on one person's artwork to allow space for other perspectives to come in.

PARTCIPANT 2: I am aware that this is a, ... just a response to that bit erm... because I often have those anxieties about the structure and making sure that there is a fairness to the group and I am aware with this group that any unfairness stimulates "why is she getting this" or "why is she getting that"

FOCUS GROUP MODERATOR: this client group do you mean?

PARTCIPANT 2: yes this client group, yeah, err ... and I often have that thing where you do run out of time

PARTCIPANT 1: mmm

PARTCIPANT 2: and a picture doesn't get spoken about and I have often found that, you know that each individual picture has some of the group, what is going on in the group in some way ... I'm not always sure if that is true but it feels as though we often come back to what was missed in the next group becomes the art gets developed and the questions are asked around it and themes emerge and there is interchange even in the images as well as a dialogue and I've done groups where I kind of think well the image is about the individual but it's always about the interpersonal experience in the group a well ... I'm not sure what that is about

NEIL SPRINGHAM: no I can see that because I was looking, it looked like the therapist was there to inter-personalise everything, be it the clock, be it the image, be it someone else's image, be it a "I can't think", be it a "me too"

PARTCIPANT 1: mmm

NEIL SPRINGHAM: be it me too, it was like it seemed a big sort of focus in what you were doing to just try and sort of bring a relational context to things people hadn't thought had a relational context to it, so I think the image ... because these images are made on their own first

PARTCIPANT 1: mmm

NEIL SPRINGHAM: and then we bring them in and we start inter-personalising them ... it's quite complex what we are asking people to do really

FOCUS GROUP MODERATOR: I suppose I was curious about the structure of the group in terms of turn taking and there was I suppose about 15 minutes focused on, not solely focused on one image as we are discussing, but with kind of that at the centre.

PARTCIPANT 1: the stage at which that was made it was a bit more erm, fluid and I started to tend to be a bit more kind of rigorous about making sure that everyone gets included erm, I think the difficulty of that is that erm, you know one person will start speaking about their image and then others can perhaps relate to it and then if their work isn't necessarily seems to be connected to what they are doing cutting that conversation off and removing them might feel a bit abrupt and so I think as a therapist I trying to take into account that everybody should have the opportunity to be included but I am kind of trying to see whether a dialogue can be developed in the group, that people can be inspired to see potential connections between their work or they relate to certain things they said erm ...

FOCUS GROUP MODERATOR: there is a lot of interesting questions there about what gets talked about and how much influence the therapist has in that and how much comes from the way people respond verbally to their and each other's images?

PARTCIPANT 1: I think what I taken with looking at the footage again was of erm, really not reminding myself that I am not trying to be too expert dispelling insights into these images because at one level they are as obscure to me as any member of the group potentially looking at something somebody has made for the first time so I think what is in my mind always is, as has been mentioned to try and open curiosity, tray and open a potential dialogue about the interpersonal experience of making the artwork and it was very much what was implicitly on my mind rather than explicitly what would come out

NEIL SPRINGHAM: but you are not just with the flow is it, it's not just being curious. There is a sort of active focus for curiosity like generating curiosity around certain areas. Did you ever get a sense of where ...

PARTCIPANT 1: well, this is very much where the, my MBT experience come in because what I am interested in is whether somebody can look at a work of art and make an inference from that work of art about their state of mind, I think that is probably why I am implicitly looking for all the time erm, and then to sort of draw out what are the kind of mentalization poles, so if somebody is full of cognitions about their artwork can that shift into then thinking about the feelings they have towards their artwork if it is all based about others, can you think about yourself. It's always trying to, well particularly with this film I think I was just subtly trying to look out for whether he could think about feelings and we get this one which is "frustration" which, you know is as a feeling still quite vague and could do with a lot more unpacking but because he was so kind of stuck in what seemed to be thoughts which seemed to be thoughts about what he should be doing, hearing a feeling about what he was actually experiencing erm, to me was trying to help him get a fuller understanding of what he might have been subjectively feeling in the group that morning, that day erm, so yeah, so that was I suppose in my mind in parallel with the artwork. Did he make an inference about it in terms of what his state of mind was that day? And could his state of mind, could he show any ability to be flexible about how he was thinking about mind, not just as thoughts but also mind being other things

PARTCIPANT 2: I think you show great strength ... I don't know, I think it was very subtle how you did that in terms of how you shifted the focus from the art-maker and the others how you move between how they talk about themselves all of us in that experience

and you could see that going on ... and I am not sure I might have pushed it a bit more, I don't know whether it would...

FOCUS GROUP MODERATOR: how do you mean pushed it?

PARTCIPANT 2: I don't know I might have just put my hands on my head and sort of "yeah I am looking at your picture and I am doing this"

PARTCIPANT 1: mmm

PARTCIPANT 2: and see what came back without actually naming the feeling ... but again, whether that is ... I don't know whether that falls within a certain ... almost like you convey a certain sense of trying to re-experience something that you are seeing and then experiencing

FOCUS GROUP MODERATOR: maybe what PARTCIPANT 1 is saying is that making quite deliberate efforts not to impose anything and limiting your expression of your perceptions certainly not interpreting, I'm not seeing any of that in your ... how it made you feel for instance, I mean you did say one or two things. Was that your stance of deliberately trying to limit what you?

PARTCIPANT 1: I certainly don't think I was deliberately trying to limit, I think was probably going on my knowledge of that patient who I have been working with for quite a while and knowing that he finds it hard to name feelings erm, ... and I think there was a question there earlier about what the stage of that group was and although I can't clearly remember it could have been that that group was a slightly newer constellation of those members or so I might not be as erm, ... I might take a bit more time if it is a newer constellation because I would prepare to feel, I didn't have enough sense that they were trusting enough whether we can push a bit more and again that would be very much in my mind ... yeah think there was a few times where, this might not come across, where I

might have slightly in the way I was speaking slightly tried to sort of overly pronounce things, whereas I think at the beginning I was making a joke about the fact that they had been talking about, well not really a joke, but they had been talking about the fact that there was too much time and I was trying to bring attention to it but to do it in a way, a sort of light hearted way and again the intention was to express curiosity in a way that was going to make them feel they were told off for not having used the time or ... something about what I was doing with my voice I think even my expressions I think, it might be quite subtle but to me I kind of recognised that my own body language that I was trying to do initially ...

PARTCIPANT 2: I think how you managed it, you were able to get to that feeling was through frustration that was how he named it

PARTCIPANT 1: mmm

FOCUS GROUP MODERATOR: that puts me in mind of another question that I have asked all the other groups which is simply do you see therapeutic change happening? How is it happening?

PARTCIPANT 2: I think in what we were just talking about, in just seeing someone really, the art-maker really struggled to articulate his experience, what he has drawn and finding a way to explain his experience and perhaps have a new experience in that process which he can share something that obviously very difficult for him to share or articulate, get his head around, to begin to think about err in the sense that that is just the beginning for this gentleman and we know that these guys really struggle with articulating the subtle feelings let alone the big emotions and that sort of de-rails everything in anyway, you know to be able to slow them down, to get them to think is quite important and I don't

know if the art maker is someone who is quite explosive or just constantly down regulates his emotions

PARTCIPANT 1: yeah, I think the latter and it is interesting that he starts off by saying something like “I’ve just done words” and the other member (service user D) who speaks she is actually referring to a second image that he did which says cant think and she says, she comments on the quality of the marks with something like “you’ve done a drawing” and I don’t think he directly comments on that but I think my feeling was that there was a bit of a surprise that he thought he had just done words which to me has a negative connotation in the way he was describing it, then he kind of was told by another member that what she sees is a drawing. I see a very subtle shift there in maybe potentially what is being presented to him about his own product by virtue of it being outside of him so being able to look at something he has done but getting a different view about how it is coming across so I think to me that, I don’t think it is therapy, but it is something that might have changed in those fifteen minutes about what the potential was there for him

NEIL SPRINGHAM: absolutely, I mean I thought you stopped him dismissing himself

PARTCIPANT 2: yeah

NEIL SPRINGHAM: and what he was saying, you know he sort of dismissed his image, dismissed the fact and I thought for this guy to be even 15 minutes not able to dismiss himself to invalidate his image and I just thought the therapy was in that for me and it is quite strange watching it just how much you can keep coming back to something where he says there is nothing and he allows that to be refuted but on the other side there seemed to be quite a lot of therapy for other people in just being immersed in that. I know it’s all on one guy but it didn’t seem the therapy was just there for that person. For instance, I felt I was watching it like other people were watching it and thinking that is really very

interesting that these things which ... it all can looked at, it can all be mentalized and to stay with it like a kind of marathon, seemed to be a lot to tolerate I thought

PARTCIPANT 2: I mean it's in the picture ... he was kept in mind, the art therapist was keeping him in mind which as you say was coming back to "we are paying attention to you" and we are also paying attention to other people's responses, we are keeping you in mind and keeping them in mind (laughs) and keeping me in mind. Its: "we mind", its spelt out in the picture it is about what is inside here which he is sharing with the rest of the group, even if it is difficult for him to articulate or get to even when the group is sort of following this process I mean they are trying to keep this all in some kind of frame which is about being interested and curious. I think it is powerful for these patients to be kept in mind because it is fundamentally it isn't a state they learned

NEIL SPRINGHAM: yeah ... it seemed like the group was a mind really, you could keep bringing things into it into the pool of light that it was looking at and I thought that was constantly quite surprising just what could come in given how often people said it was nothing. I thought other people and (service user D) commenting on his work, I thought there might be therapy there as well ... the equality of how the therapist treats what she says with what they say. It didn't seem to be so simple that it is this guy's time for therapy and everyone else just listened to the therapist, it seemed much more diffused than that and that surprised me. Predominantly he gets the intense experience but I wasn't feeling that that was to exclusion of other people who were just waiting for their turn to get therapy

PARTCIPANT 2: I could see that. The group was listening and paying attention

PARTCIPANT 1: yeah, that was my feeling. I did think there was something, a quality of (service user D)'s response where she seems to, it's very subtle, but she seems to

empathise with him and relating it to herself, so it is that dual, it's not just doing it to him, it's not just about me, it's in that moment it seems to be both going on

PARTCIPANT 2: what you were saying matters to her

PARTCIPANT 1: yeah, about him and about her

NEIL SPRINGHAM: for some reason it is reminding me of the bit where say "no one wants to be made a fool of, no one wants to feel a fool" and I thought there was something about two way streets, probably just a cul-de-sac or one way street, in these ideas I am locating these things in this diffused way. I saw some of the therapy in that really

FOCUS GROUP MODERATOR: just one other addendum to that, I was wondering that just at the end the art maker points out the question mark, and he seemed to not have very long with that but seemed to find some commonality and seemed to be identifying that and sort of reciprocating in a sense as she had been doing with his image

PARTCIPANT 1: mmm ... that is interesting because he is somebody who certainly early on a part of his treatment which lasts for 18 months and he is towards the end now, in the very early stages if you would focus on him for any length of time he expressed it as a relief when things moved away from him and actually there seemed to be a kind of curiosity about him but it didn't seem to necessarily give any indication of "oh, I am glad it's off of me now" which led me to believe maybe he was comfortable with being in the focus, maybe he was getting something from that attention and perhaps he wanted to give (patient D) something because he had been given something... but his curiosity seems genuine I thought .